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Health Services in Britain

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Health Services in Britain

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INTRODUCTION

BRITAIN'S publicly provided health services are mainly a development of the past 125 years, though there was some previous provision by local authorities and voluntary organisations. In the Middle Ages a number of religious orders cared for the sick, while town councils issued elementary sanitary regulations. In the sixteenth century the Reformation swept away most of the religious orders, but under the Poor Law Act 1601, local authorities were given the duty to provide the sick, the needy and the homeless with the means of subsistence. They also began to take some steps to control water supplies and to try to check epidemics. In the eighteenth and nineteenth centuries British medical services developed. Medical science advanced and the number of qualified doctors greatly increased. Hospitals were built with private endowments and subscriptions and were made increasingly available on a charitable basis to the general population, while free 'infirmaries' were provided under the Poor Law for the destitute, aged and infirm. The provident poor began increasingly to insure against the time of illness by subscribing to provident and friendly societies and sick clubs. Many public-spirited medical practitioners would at that time forgo or cut their fees to poor patients.

Public measures to promote healthier living conditions, however, preceded adequate public provision for the care of the sick. Rapid growth of towns in the first half of the nineteenth century caused an intensification of sanitary problems, with consequent cholera, typhus and other epidemics. A programme of sanitary reform, associated particularly with the name of Thomas Chadwick, led to the passing of the Public Health Act 1848, an epoch-making measure which, for the first time, established a comprehensive public health system under unified control and laid down minimum standards for its services. The system was further developed and consolidated by the Public Health Act 1875, upon which all subsequent public health legislation has been based.

In the twentieth century the provision for personal health services began to improve rapidly as the result of the progress of medical knowledge and the wider availability of treatment. The National Health Insurance Act 1912 introduced a scheme whereby all people earning wages of less than £160 a year (later raised to £420) were entitled to the services of a general practitioner in return for regular contributions made by themselves and their employers to certain insurance organisations, known as approved societies. The doctors who took part were paid a capitation fee for the patients who had asked to be on their list and been accepted. This scheme came to cover most of the poorer half of the population while the other half was dependent for their medical care either on paying fees as private patients, or on a certain number of voluntary sick clubs (a form of voluntary insurance whereby people paid the doctor a few pennies a week).

At the same time the voluntary hospitals expanded their free services for the poor with the aid of voluntary donations and contributions and the fees of other patients, while after 1929 the Poor Law Infirmaries began to develop into local authority general hospitals. Some local authorities began to

provide improved social and health services, mainly for schools, mothers and children.

These various health services, however, were unevenly distributed and were seen to be inadequate. Proposals for a full health and medical service were the subject of many reports in the inter-war years. It was, however, the second world war which precipitated reform in this, as in many other matters. To deal with the war-wounded, the Emergency Hospital Service, including both voluntary and municipal hospitals, was extemporised on top of the existing organisations. The welfare food service for mothers was introduced and school meals services and industrial canteens were expanded. In 1941 an inter-departmental committee was set up under Sir William (later Lord) Beveridge to conduct a survey of the existing national schemes of social insurance and allied services and to make recommendations as to the way that social services should be reconstructed after the end of the war. The committee's report, known as the Beveridge report, was published in 1942; it recommended far-reaching changes involving a considerable extension of both the health and social security services and formed the basis of much post-war social legislation. In 1943 the wartime all-party government announced its acceptance of the proposal in the Beveridge report that a comprehensive health service for all purposes and all people should be established. The first plan for a comprehensive National Health Service was published by the Government in 1944 (Cmd 6502). The final plan was embodied in the National Health Service Act 1946, and corresponding legislation for Scotland and Northern Ireland, and the National Health Service (NHS) began to operate on 5 July 1948, providing a complete general practitioner and hospital service for the community and expanding the environmental and community health services (as well as the associated personal social services) provided by local authorities.

The system then introduced was an immediate success in the sense that almost everyone used the service and the great majority of doctors took part in it. The basic structure of the service with its tripartite division into hospital, general practitioner and local authority services, lasted till April 1974. There were, however, a number of changes and developments in the intervening years. Charges were introduced for part of the cost of certain parts of the service, for example, prescriptions, dental work and spectacles, though certain groups of people, essentially the young, the old, the chronic sick and the very poor, were exempted from some or all of these charges. A series of reports led to changes in the mental health service, in the organisation of hospital doctors' work, and the structure of the nursing profession. These and other reports high-lighted the need for more efficient organisation, closer integration of the three parts of the service, and better liaison with the social services, particularly in order to deal with the vast socio-medical problems of disability, old age and chronic illness.

During the 1960s, general practitioners began increasingly to join together in larger partnerships or group practices, to which home nurses, health visitors and other local authority paramedical staff were attached, while a number of health centres began to be established by local authorities. In 1972 and 1973, after a series of Green (Consultative) and White (Policy Making) Papers on reorganisation, legislation introducing major structural

reforms was introduced first for Northern Ireland and Scotland, and then for England and Wales. A new structure was introduced for Northern Ireland on 1 October 1973, and for England, Wales and Scotland on 1 April 1974, at the same time that there came into operation in England and Wales a new local authority structure, and a new system of regional water authorities, responsible for water supply, sewerage and sewage disposal. In Scotland reorganisation of local government is scheduled to take effect from 13 months later, i.e. from May 1975.

Improvements in health services, together with advances in science and raised standards of living, have been reflected in the vital statistics. Death rates of children and young people fell rapidly and continuously over the whole period from 1870 to 1930, while death rates of older people also fell, but more slowly. During this period the mortalities from tuberculosis, enteric, smallpox and the main infective diseases of childhood were dramatically reduced. From 1930 to 1950 death rates of people under 35 fell even more rapidly, probably in part owing to the introduction of antibiotics and the wider use of immunisation, for example, against diphtheria. On the other hand, the death rates of men aged over 55 actually rose. From 1950 to 1960 (the decade following the introduction of the National Health Service) death rates fell in all age groups, but since 1960 the rates for England and Wales have changed little except for some further reductions for children under 4 years old, and for people over 75. There has, however, been a considerable further reduction in the death rates of women of all ages in Scotland and Northern Ireland, which are now only a little higher than those for England and Wales. During this recent period the fall in death rates from acute infective and parasitic diseases (other than respiratory diseases) has tended to flatten out, while there has been some further increase in death rates from bronchial pneumonia and bronchitis, cancer and cardiac diseases.

The overall effect of the continuous long-term decline in death rates has been greatly to increase the expectation of life at birth, in England and Wales from 40 years for males and 42 for females in 1841 to 69 for males and 75 for females in 1970. Maternal and infant mortality in Britain are among the lowest in the world, and the physique of children continues to show marked improvement. In the mid-1930s the average child aged 7 was already as tall and heavy as the average 8-year-old child 30 years earlier, and reports of school medical officers show that school children in Britain today are healthier, taller and generally of better physique than those of 20 to 30 years ago.

Ministerial responsibility for health services in Britain is divided between the Secretary of State for Social Services, responsible in England, the Secretaries of State for Scotland and Wales, responsible in Scotland and Wales respectively, and (normally) the Minister of Health and Social Services in Northern Ireland. There is separate legislation for Scotland and Northern Ireland, and some of the arrangements differ accordingly, but in all four countries of Britain the general organisation and functions of the health services are on broadly similar lines. This pamphlet therefore gives in the first place an account of the structure and functioning of the services as they exist in England and then devotes chapters to the distinctive features of the separate arrangements in Wales, Scotland and Northern Ireland.

ORGANISATION IN ENGLAND

A NEW administrative structure for the health services in England was laid down by the National Health Service (Reorganisation) Act 1973 which also dealt with reorganisation in Wales. It became effective on 1 April 1974. It is based on the establishment of health authorities, statutory agencies of central government, responsible within defined areas for all health services, including hospital and specialist services, the primary health care services (including general practitioner services and the personal health services previously administered by local authorities) and the School Health Service, which was previously run by the education authorities but now forms part of a comprehensive Child Health Service. These health authorities have also a general responsibility for preventive health measures and co-operate with local, port, and water authorities, which have certain defined responsibilities and powers in relation to environmental health. The employment medical service, however, with its limited defined objectives, remains outside their direct responsibility.

In England there is a three-tier structure for planning and control. At the centre is the Secretary of State for Social Services, answerable to Parliament and acting through the Department of Health and Social Security, the central authority responsible for national planning; for developing and providing resources, allocating them to the 14 Regional Health Authorities (see below) and monitoring their performance; and for carrying out some functions best organised centrally, including certain types of research. The Secretary of State is advised, not only by the officers of his department but by the Central Health Services Council, appointed by him and the Secretary of State for Wales to be representative of the medical and associated professions and their professional bodies and to include some persons representative of the public; and by the council's standing advisory committees—medical, dental, nursing and midwifery, pharmaceutical and ophthalmic.

Regional Health Authorities

The boundaries of the 14 Regional Health Authorities (RHAs) are similar to those of the previous NHS hospital regions. Each region contains at least one university medical school. Each regional authority is responsible for regional planning; the provision of services and allocation of resources to Area Health Authorities (see below) and the monitoring of their performance; and the support of university teaching and research. It is accountable to the central department and delegates responsibility to its constituent area authorities, which number between 3 and 11 per region.

One of the most important of the regional authority's executive functions is the design and construction of new buildings and works. It undertakes the more important projects itself, and delegates other new building work to the area authorities. It employs architects, engineers and quantity surveyors not only for its own work, but to help the area authorities with their building projects.

The chairman and members of a regional authority are appointed by the Secretary of State after consultation with interested organisations, including

universities, the main local authorities, the main health professions and the workers organisations. Members are unpaid (but entitled to travelling and other allowances) but the chairman is paid on a part-time basis.

Area Health Authorities

There are 90 Area Health Authorities (AHAs) in England whose boundaries generally match those of the new non-metropolitan counties and metropolitan districts of local government. In London the health authority boundaries correspond to those of an individual London borough in four cases, and to those of two, three or, in one case, four London boroughs grouped together in the remaining 12 cases.

The *AHA* is the operational *NHS* authority, responsible for assessing health needs in its area and for planning, organising and administering area health services to meet them, including the necessary supportive services.

The chairman of an area authority is appointed by the Secretary of State after consultation with the chairman of the relevant Regional Health Authority. Membership of AHAs ranges from 15 to 28, generally four of whom are appointed by the corresponding local authority; one by the university concerned (more in areas with substantial teaching facilities) and the remaining members by the RHA after consultations with the main health professions and interested organisations, including federations of workers organisations. Membership always includes at least two doctors, and one nurse. Members are unpaid (but entitled to travelling and other allowances) but there is provision in the legislation for the chairman to be paid on a part-time basis.

Areas which have substantial medical, teaching and research facilities are known as 'teaching areas', and the Area Health Authorities which administer them are called Area Health Authorities (Teaching)—AHA(T)s. Whereas the area authority without substantial teaching and research facilities has one member nominated by the university, the area authority (teaching) has two. It also has at least two additional members with teaching hospital experience—more if the area includes more than one teaching hospital (or groups of hospitals of a kind hitherto designated as a single teaching hospital).

Though the teaching areas are administered as part of the regions in which they are situated, the teaching hospitals preserve their individual identities and historic traditions and their close links with university medical and dental schools.

Health Districts

The day-to-day running of the services for which an AHA is responsible is based on health districts. These always contain a district general hospital and usually have a population of between 100,000 and 500,000. The area authorities decide the number of districts in their areas which in fact vary from one to six.

The execution of health policies in a district is in the charge of the district management team, consisting of four officers of the AHA, namely a district administrator, a district finance officer, a district nursing officer, and a district community physician, joined by two clinicians elected by the district medical

committee, which is representative of the doctors working in public health, the medical and dental hospital staff and general practitioners.

Local doctors can thus have a say in planning and decision making, at the local level through the representative system. There is also provision for consultation with advisory bodies representative of professional interests at both regional and area level, through the area and regional advisory committees.

District management teams establish care planning teams to conduct detailed planning of the health care of particular groups of patients, for example expectant and nursing mothers, children, the elderly, the mentally ill and the mentally and physically handicapped.

Family Practitioner Committees

In addition family practitioners—general medical, general dental and ophthalmic practitioners and pharmacists in retail practice—in England and Wales preserve a special position of independence *vis-à-vis* the health authorities. They are not employees of the Area or Regional Health Authorities, nor under contract to either of them. They are independent contractors individually under contract to family practitioner committees, which are directly responsible to the central department for administering the arrangements for the provision of practitioner services for the population served by the area authorities. The committee administers terms of service, including remuneration schemes (which are settled nationally), and administers statutory disciplinary arrangements. It also advises the area authority on planning of services, development of premises, and arrangements for integrated services. Family practitioner committees have 30 members made up in the same way as the former executive councils outside London. Half of the members are appointed by the professions. Of the other 15, 11 are appointed by the Area Health Authority and 4 by the local authority entitled to appoint members to the Area Health Authority.

Democratic Safeguards

To represent the views of the consumer, there is a Community Health Council for each health district. Half the members of each council are appointed by the local authorities concerned with the district, at least one-third by voluntary bodies concerned locally with the National Health Service, and the remainder by the Regional Health Authority after consultations with the local authorities and other organisations. Members are unpaid.

As a further protection to the public, the National Health Service (Reorganisation) Act 1973 provided for the appointment of a Health Service Commissioner for England and a Health Service Commissioner for Wales to investigate complaints from the public about health services. In fact, Sir Alan Marre, who, as Parliamentary Commissioner for Administration, has since 1971 investigated complaints from the public about their treatment by public authorities, if these are channelled to him by Members of Parliament, has been given the additional tasks of dealing with health service complaints, direct from the public, not only in England and Wales, but in Scotland under separate legislation (see p. 38).

His job is to investigate complaints from members of the public who consider they have suffered injustice or hardship as a result of:

(a) failure in a service provided by a health authority;

(b) a failure by one of these authorities to provide a service which it has a duty to provide;

(c) maladministration affecting any other action taken by or on behalf of one of these authorities.

Before the Commissioner can investigate a complaint, normally it must first have been brought to the attention of the authority responsible for the service involved. The authority must have been given an adequate opportunity to investigate the complaint and to reply. Any complaint must normally reach the Commissioner within one year of the event to which it relates. Complaints concerning Ministry of Defence hospitals or the State Hospital, Carstairs, are the concern of the Parliamentary Commissioner for Administration.

In a number of circumstances, the Commissioner cannot investigate a complaint. These include:

(1) if the aggrieved person has appealed to a tribunal or taken proceedings in a court of law (or has such a right, and could reasonably be expected to use it);

(2) if the complaint relates to what are judged to be purely clinical matters;

(3) if it relates to professional services provided by doctors, dentists, pharmacists or opticians under contract to family practitioner committees or, in Scotland, health boards (for which other complaints machinery exists);

(4) if it involves staff appointments, pay, discipline, superannuation or other personnel matters;

(5) if a contractual or commercial transaction is involved;

(6) if an investigation would conflict with the protective functions of the Scottish Mental Welfare Commission;

(7) if the complaining body is a local authority, nationalised industry, or a body appointed or financed by the State (since the Commissioner's role is primarily to investigate complaints by individuals, not to adjudicate between public bodies).

PUBLIC HEALTH

UNDER the National Health Service (Reorganisation) Act 1973, health authorities in England have a general responsibility for the prevention of disease, and co-operate for this purpose with local, water and port authorities, which have certain specific responsibilities in regard to environmental health and certain specific powers of inspection and control.

The local authorities mainly concerned are the district councils, the London borough councils, and the City of London Council. Their responsibilities and powers derive mainly from the Public Health Acts of 1936 and 1961, and the Health Service and Public Health Act 1968, though there are a number of other Acts dealing with specific aspects of public health. Under the main Acts local authorities (under the general direction of the Department of Health and Social Security and the Department of the Environment) have extensive powers for making and administering by-laws on matters of public health, and for administering regulations made by the Secretary of State for the Environment. In exercising their powers, however, the local authorities need to act in close consultation and co-operation with the health authority. To achieve this, district community physicians have been appointed with dual responsibilities to the health authorities and the local authorities, thus exercising both local government and health authority functions.

Environmental health measures are directed to maintaining living conditions conducive to health and to checking the spread of disease. Among the more important measures are those relating to water supply and sewage; clean air; good housing; control of infectious disease; and health control at seaports and airports.

Water Supply and Sewerage

In April 1974 the primary responsibility in England for water conservation and supply, and sewerage and sewage disposal was transferred under the Water Act 1973 to nine regional water authorities, though these may and do use existing water undertakings and local authorities as their agents in respect of water supply and sewerage. At the same time, the water authorities took over the river management functions previously exercised by river authorities. As part of their responsibility for environmental health and consumer protection, local authorities maintain the duty to take from time to time such steps as may be necessary to ascertain the sufficiency and wholesomeness of water supplies within their area, and have now a duty to notify the water authority of any insufficiency or unwholesomeness.

The regional water authorities assumed control over water development and supply, at a time when a large programme for reducing pollution in inland waters was already under way. Planned public expenditure on water and sewerage services for the five years starting 1972–73 is approximately £1,650 million at November 1973 prices, compared with an actual expenditure of £1,535 million in the five years to the end of March 1974 (also at November 1973 prices).

Clean Air

Under the Clean Air Acts 1956 and 1968 local authorities have power to control emissions of dark smoke, grit and dust and to establish smoke control areas in which (if the order is confirmed by the minister responsible (in England, the Secretary of State for the Environment) the emission from chimneys of any type of smoke (not merely dark smoke) is prohibited, except in so far as certain exemptions from a smoke control order may be given. Householders in smoke control areas may receive a grant towards the cost of necessary work of installing appliances burning smokeless fuel. By the end of 1973 about 6·3 million dwellings and commercial premises were subject to smoke control. In addition, the Alkali and Clean Air Inspectorate is responsible in England, under the Secretary of State for the Environment, for enforcing control of emissions to the air of noxious and offensive substances, including smoke, grit and dust from certain industrial processes. All works controlled under the Alkali, etc, Works Regulation Act 1906 must be registered annually and the owners are required to use the best practicable means to prevent the emission of noxious or offensive gases and to render such gases harmless and inoffensive if they are discharged. Industrial premises not controlled under the Alkali Act are the responsibility of the local authority. The emission of smoke on motor vehicles is also controlled.

The Clean Air Council (set up in 1956) reviews the progress made in abating air pollution in England and Wales. Partly as a result of air pollution control London no longer experiences dense ('pea-souper') fogs or serious smogs, and in central London winter sunshine has increased by 70 per cent since 1962.

Good Housing

Under the Public Health Acts and the Housing Acts local authorities are responsible for securing the repair, maintenance and sanitary conditions of houses, the proper management of dwellings occupied by more than one household, the clearance and redevelopment of unhealthy and congested areas, the abatement of overcrowding and the provision of housing accommodation to meet local needs. Landlords are required by law to keep their house property in a fit state for human habitation, and, if they allow it to fall below the prescribed standards, the local authority may require them to carry out repairs, or, if these are not done, may carry out the repairs itself and recover the cost. If the property cannot be rendered fit for habitation it can be closed and scheduled for demolition.

Control of Infectious Diseases and Food Poisoning

Local authorities are responsible to the Secretary of State for Social Services for investigating outbreaks of infectious diseases and food poisoning, for carrying out disinfection and various other preventive measures, and for recording notifications of prescribed infectious diseases. Most local authorities have appointed as their 'proper officer' to deal with infectious diseases and food poisoning, a doctor who is also a community physician of the health authority, and as such has a general responsibility for the prevention and control of disease.

Health Control at Seaports and Airports

The same arrangements also generally apply to the 'proper officers' who supervise health control at seaports and airports, primarily in order to prevent the introduction of infectious disease into the country. They are responsible both to the Area Health Authority and to the local authority.

Health control is applied in accordance with the Public Health (Ships) and (Aircraft) Regulations 1970 as amended 1974, which, among other things, implement the international health regulations, including amendments, adopted by the World Health Organisation. At seaports the regulations are applied by the port medical officer (the 'proper officer'), assisted by port health inspectors, rodent officers and others. At airports the airport medical officer (the 'proper officer') is responsible for applying the regulations.

The control in normal circumstances is not onerous, and may consist of a rapid scrutiny of all arriving passengers, with a more detailed examination for special cases or the issue to passengers from certain areas of 'warning notices'. In abnormal circumstances—for example, the arrival of a ship with infection on board—more elaborate precautions are taken. Actual or suspected cases of infectious disease can be detained at any time, and contacts can be placed under surveillance. Up until 31 December 1974 travellers arriving in Britain are required to produce a valid international certificate of vaccination against smallpox if, within the preceding 14 days, they have been in an infected area, as notified by the World Health Organisation, anywhere in the world, and all travellers over one year of age from any territory outside Europe (which term includes Cyprus, Greenland and Turkey) but excepting Canada, the United States, the Azores, the Canary Islands, Madeira, French Guiana, Guadeloupe, Martinique and Reunion, St Pierre and Miquelon, Surinam, the Netherlands Antilles, Algeria, Libya, Morocco, Tunisia, Israel, Mexico, the Caribbean islands and Bermuda, Guyana, and, in respect of trans-polar, trans-Pacific and trans-Siberian flights, Australia, New Zealand and Japan. From 1 January a certificate will be required only from travellers who within the preceding 14 days have been in a country, any part of which is affected with smallpox.

Apart from this health control, certain categories of aliens and Commonwealth immigrants arriving in the country may be medically examined under the Immigration Act 1971.

Immunisation

In April 1974 the Area Health Authorities took over from the local authority health departments their planned programmes of vaccination and immunisation against diphtheria, measles, rubella (girls only), poliomyelitis, tetanus, tuberculosis and whooping cough. Such protection is given either in family doctors' surgeries, or in health centres or at child health clinics (see p. 25).

Area Health Authorities also make arrangements, in certain circumstances, for the vaccination of persons intending to travel abroad and of certain groups at special risk of contracting anthrax or rabies because of their occupation.

Public Health Laboratory Service

The Public Health Laboratory Service is an Exchequer-financed service run by a special board appointed by the Secretary of State for Social Services

and the Secretary of State for Wales. It provides a network of bacteriological and virological laboratories throughout England and Wales which assist in the diagnosis, prevention and control of infectious diseases, and conduct research. Its largest establishment is the Central Public Health Laboratory at Colindale, in north-west London, which includes the National Collection of Type Cultures, the Standards Laboratory for Serological Reagents, the Food Hygiene Laboratory, the Epidemiological Research Laboratory, and reference laboratories specialising in the identification of infective micro-organisms. In addition to the central laboratory, there are regional laboratories and area laboratories.

Pure Food

The composition, labelling and description of food, food hygiene and the safety and fitness of food are controlled by the Food and Drugs Act 1955. The question of the composition, labelling and description of food are the concern of food and drugs authorities (county councils, London borough councils and the City of London Council) and questions of food hygiene and the safety and fitness of food are the concern of district councils. The Department of Health and Social Security and the Ministry of Agriculture, Fisheries and Food are the central departments responsible for giving advice and making regulations. Premises where food or drink is prepared, handled, transported or sold must conform to certain hygiene standards. Authorised officers of the councils may take for analysis or for bacteriological or other examination samples of any food for sale for human consumption.

Safety of Medicines

The Medicines Act 1968, replacing previous less comprehensive legislation, provides for the control of medicinal products and certain other substances and articles through a system of product licences and clinical trial certificates and the licensing of firms and persons engaged in the manufacture or assembly of such products or in wholesale dealing in them. The licensing authority (consisting of the health and agriculture ministries of Britain acting individually or in concert) is advised by the committees appointed under the Act—for human medicines the Committee on Safety of Medicines, which has replaced the former Committee on Safety of Drugs, and, for veterinary medicines, the Veterinary Products Committee, which has succeeded the Veterinary Sub-committee of the Advisory Committee on Pesticides and other Toxic Chemicals. The Act also consolidates and extends provisions relating to the retail sale and supply of medicines. It provides for a new list of medicines available only on a doctor's prescription and that all medicines, except those specified in a general sale list, shall be sold only from registered pharmacies (for registration, see p. 20).

The Act also provides for the regulation of advertising and labelling of medicines to secure correct identification, valid claims, appropriate dosage information and warnings, and the promotion of safety.

The supply of addictive drugs is controlled by the comprehensive provisions of the Misuse of Drugs Act 1971. Britain is a party to all the international treaties for the control of drugs, except the 1936 Convention For The Supervision of Illicit Traffic in Drugs, and the 1953 Opium Protocol.

Other Environmental Health Duties

The public health function of local authorities also include street cleansing and refuse disposal, the provision of burial grounds, the provision of baths and wash-houses, disinfectation and rodent control, and the abatement of noise and vibration nuisances and other nuisances, such as those arising from the processes of offensive trades.

Under the Public Health Acts, local authorities have power to regulate the provision of sanitary conveniences in places of work (as well as in houses), to treat unclean or dangerously overcrowded or ill-ventilated places of work as nuisances and to ensure improvement. (For other industrial health measures, see pp. 32–36).

THE NATIONAL HEALTH SERVICE

PERSONAL health services are available to people normally resident in Britain according to medical need without regard to any insurance qualification. National insurance contributors are required to pay a weekly national health contribution, but contributors and non-contributors are entitled to the same full range of services. All the services were originally free to users but various charges for certain of the services have been introduced under subsequent legislation, though these can be waived under certain conditions.

All but a very small proportion of the population resident in Britain use the services, though a number of people also occasionally pay for a private consultation and/or treatment (see Appendix 1, p. 54). Similarly, nearly all doctors and dentists take part in the service, but this does not debar them from also taking private paying patients, and many do so. However, only a small minority of specialist consultants, about 2 per cent of general medical practitioners and a practically negligible number of dentists, retail pharmacists, ophthalmologists and opticians, take no part at all in the National Health Service.

A small number of hospitals remain outside the service, but many of them treat National Health Service patients under contractual arrangements. Most of them are run by religious orders. Some, such as the Italian and Jewish hospitals, serve a special group of patients. Others are maintained for the chronic sick or for convalescence by charitable organisations. There are also private nursing homes, which must be registered (see p. 54).

A statistical summary of the staff, hospitals and beds available under the National Health Service is given in Appendix 6, p. 64.

Though visitors from abroad who come to Britain specifically for treatment are expected to pay for it, treatment can be given under the emergency provisions of the service to any visitor who falls ill during his visit. Certain countries also have arrangements under which they extend to British nationals in their countries some or all of the rights to medical treatment enjoyed by their own nationals. These countries fall into four main groups:

(1) The member countries of the European Community, in each of which the families of British nationals or stateless persons resident in Britain and working for a British employer or receiving British social security benefit are entitled under Community regulations to urgent medical treatment on the same basis as nationals of that country.

(2) Countries which provide treatment under their scheme to both resident and visiting British nationals. Austria, Bulgaria, Denmark, Norway, Sweden, Poland and Yugoslavia do this under reciprocal agreements with Britain, while New Zealand does it under its own legislation.

(3) Countries which provide treatment to British residents on condition that they are members of a state sickness insurance scheme. In general, this means people who are employed there or are the recipients of certain insurance benefits under local or British legislation. The only example outside the European Community is now Switzerland.

(4) Countries which provide limited treatment for certain beneficiaries

under the British insurance scheme. These are Australia (which provides treatment for persons who qualify for the Australian Supplementary Pension), Israel and Malta (which provide treatment for people receiving certain industrial injury benefits and, in the case of Israel, for women who are entitled to a maternity grant under the provisions of the British national insurance scheme).

The services available are provided on the same basis as to nationals of the countries concerned, and are not always entirely free. None of the reciprocal health agreements entitles a person who comes to Britain specifically for medical treatment to use the National Health Service.

Finance

Public expenditure on the national health services in Britain was estimated at £3,400 million in 1973–74. Most of the cost fell on the Exchequer while the rest was met from local rates (as the local authorities still had extensive community health functions) and from the national health service contribution paid with the national insurance contribution. In addition charges paid by people using certain services amounted to some £100 million.

There are charges for prescriptions (except for children under 16 years old, expectant and nursing mothers, men aged 65 and over, women aged 60 and over, patients suffering from certain medical conditions, war and Service pensioners, and families with very low incomes, including those receiving supplementary benefits and family income supplement), for treatment in the dental service (but not for examination only or for treatment given to people under 21 years or women who are pregnant or have borne a child in the past year), for dentures (except for children under 16 or still at school, and women who are pregnant or have borne a child in the past year), for spectacles (except children's spectacles) and for certain other articles and services (see p. 20). Certain exemptions or refunds are made and help with health service dental and optical charges can be given under the supplementary benefits scheme to anyone aged 16 or over whose income is below a certain level. A limited number of beds may be made available for hospital patients wishing for privacy, provided that this accommodation is not needed on medical grounds for non-paying patients; a charge for part of the cost of the accommodation is made. Provision is also made at certain hospitals for patients to be treated as private patients on payment of the whole cost of their accommodation and treatment. Such patients may make private arrangements for treatment by doctors of their own choice.

Hospital medical staff are either full-time and salaried or part-time. The senior grade of hospital specialists, the consultants, may elect to be full-time and salaried or part-time and paid on a sessional basis. Part-time consultants may accept private patients. Below the consultant grade the vast majority of staff are full-time and salaried. General medical practitioners are paid a basic practice allowance; special allowances for seniority, practice in groups, practice in under-doctored areas and as recognition of vocational training; a capitation fee for each patient on the practice list; payments for out-of-hours work and some item of service payments, for example vaccinations. Repayments are also made of expenses incurred for rent and rates and employment of some ancillary staff, in whole or in part.

Dentists providing treatment in their own surgeries are paid on a prescribed scale of fees according to the treatment they have carried out. Pharmacists dispensing on their own premises are paid on the basis of the prescriptions they dispense. Ophthalmic medical practitioners and ophthalmic opticians taking part in the general ophthalmic service are paid approved fees for each sight test made; opticians who dispense spectacles are paid according to the number and type of pairs supplied.

PRIMARY HEALTH CARE

PRIMARY health care, the front line of the personal health services, is in the hands of doctors, dentists, opticians and pharmacists working within the service, some of them as independent practitioners, and home nurses, midwives and health visitors employed by the health authorities.

Family Doctor Service

The general medical practitioner—or family doctor as he is more usually known—plays a key role in the National Health Service. He has detailed knowledge of his patients and their families, their background and the environment in which they live and work. He is their first line of defence in case of illness, and acts as a link between them and other parts of the National Health Service.

Through the family doctor service the professional attention of a family doctor of his own choice is made freely available to everyone—and about 97 per cent of the population take advantage of this and are registered with family doctors throughout the country.

Everyone aged 16 or over may choose his own doctor (parents or guardians choose for children under 16), and a doctor is free to accept a person as a patient, or not, as he wishes. However, he must, for instance, give any necessary treatment to any person who applies to him for treatment when he is not on the list of another doctor or who needs treatment in an emergency and his own doctor is not available. A person may change his doctor if he wishes. This may be done immediately if he has changed his address, or has obtained the consent of his doctor, or has been notified that he may change his doctor as a result of a change in the location of the doctor's surgery. Where these circumstances do not apply, he may still change his doctor, but to do so, he must apply to the family practitioner committee, and the transfer will take at least 14 days. If a person is unable to find a doctor who can or will accept him, he may apply to the local family practitioner committee, which will help him to find a doctor.

When people are away from home they may still obtain, as 'temporary residents', any necessary treatment from a doctor in the area in which they are staying. Anyone staying in a district for not longer than three months may receive treatment on this basis, even if he has not previously used the general medical services. If he is not staying in a district for more than 24 hours, and needs treatment urgently during this period, he is treated as an 'emergency' patient.

The general practitioner has complete clinical freedom to treat his patients according to his professional discretion. There are no regulations as to which drugs or treatment he should or should not prescribe, although doctors are expected to bear in mind the cost and therapeutic value of the drugs they prescribe and there is provision for the investigation of improper or excessive prescribing. If a serious illness develops or diagnosis is difficult, the family doctor may call a consultant and secure hospital treatment for his patient.

Doctors already practising in an area before 5 July 1948 were entitled to join the National Health Service in that area and to continue practising as

before, and almost all doctors now choose to practise in the National Health Service. Doctors are not told where they should practise and are free to do so in most parts of the country, but since it is one of the aims of the National Health Service to improve distribution of doctors so that everybody may have an equal chance of first-class medical attention, a doctor who wishes to start a new practice, or to apply for a vacant practice, must first submit an application to the Family Practitioner Committee (see p. 6). The committee then forwards it with its recommendation to the Medical Practices Committee, appointed by the Secretary of State for Social Services and consisting of a doctor chairman, six other doctors and two lay members. This committee surveys the need for doctors throughout the country and may refuse applications to practise in areas where additional doctors are not considered to be necessary. The doctor whose application is refused by this committee has a right to appeal to the Secretary of State against the decision.

A doctor in single-handed practice may have up to 3,500 patients on his National Health Service list, and, if he is practising in partnership, he or any of his partners may have up to 4,500 patients, so long as the average of the combined lists does not exceed 3,500 for each partner.

Good organisation in general practice is encouraged by giving financial help to general practitioners in meeting expenditure on rent and rates of practice premises and on the employment of ancillary staff.

Doctors give personal attention to their patients, unless they make suitable arrangements for a deputy to attend them. Where possible, patients are expected to attend at the doctor's surgery for treatment, either by appointment or during surgery hours. However, patients who are too ill or unable for some other good reason to attend at the surgery can ask the doctor to visit them at home. A doctor may prescribe any drugs or medicines, and certain appliances, which he considers necessary for a patient's treatment; the patient takes the prescription to the nearest chemist and receives his medicine. In rural areas, a doctor may dispense any necessary drugs and medicine for those of his patients who have serious difficulty in obtaining them from a chemist because of distance.

A family doctor is required to give his patients all necessary and appropriate treatment within the sphere of general medical services. He is not expected to give treatment involving special skill or experience outside the scope of the training and practice of the general practitioner, and if a 'second opinion' is required from a specialist in a particular field, the general practitioner may refer his patient to a hospital, or in special circumstances may arrange a consultation in a patient's home. Where a patient requires an X-ray, a pathological examination, or needs to attend as an in-patient or an out-patient at a hospital for specialist treatment, or needs any other services provided under the Health Service Act, it is the family doctor who takes the necessary steps to arrange these. Except in an emergency, patients are not expected to approach a hospital for treatment except through their own family doctor. Similarly, it is the family doctor who will usually advise and help his patients to take advantage of local authority social services.

General practitioners are required to sign medical certificates for their patients where the latter wish to claim certain benefits, for example, maternity

or sickness benefits under the National Insurance Acts, or benefits for injury or disablement under the National Insurance (Industrial Injuries) Act.

Remuneration of Family Doctors

The method of remunerating doctors providing general medical services under the National Health Service was reviewed in 1965–66 and a system was introduced which was designed to reflect as closely as possible the individual doctor's work load and responsibilities and his practice expenses. Under the old system, remuneration was based almost entirely on capitation fees paid according to the number of patients on the doctor's list. Under the new system, in addition to the ordinary capitation fee, there is a higher fee for patients aged 65 or over. A basic practice allowance is also paid in recognition of basic practice expenses and commitments, to which there are additions for practising in an area which has been short of doctors for several years, for practising in a group, for seniority, and for vocational training.

There are also additional payments for accepting responsibilities out of normal hours, for visits to patients at night, for treating temporary residents, for maternity services and for expenses associated with rural practice. In addition, fees are paid for particular items of service including those which are encouraged as a matter of public health policy, such as vaccination and taking cervical smears. Direct payments are also made for the rent and rates of practice premises and for expenditure on ancillary staff.

General practitioners may also obtain Exchequer grants towards improving their practice premises and a finance corporation has been set up to make loans for the purchase, erection and improvement of premises.

General Dental Service

Through the general dental service, patients are provided with all forms of treatment which the dentist considers necessary for dental fitness. As in the family doctor service, there is complete freedom of choice by patients of dentists, and by dentists of patients; and dentists may take private as well as National Health Service patients if they wish. A major difference from the family doctor service is, however, that patients are not required to register with dentists, and the normal practice is to visit a dentist's surgery by appointment. In addition to the general dental service, dental treatment may also be carried out at dental hospitals as part of the hospital service.

Dentists providing treatment in their own surgeries as part of the general dental service are paid on a prescribed scale of fees, which are only partially covered by charges to patients. Unless they are exempt (see p. 14), patients must pay half the cost of any treatment up to a maximum charge of £10 for a course of treatment. There are, however, no charges for clinical examination, arrest of bleeding or repairs to dentures.

Most dental treatment, including fillings and root treatment, extractions not requiring replacement by dentures, and ordinary denture repairs, may be given without reference to any outside authority; but extensive and prolonged treatment of gums, some dentures, crowns and inlays and special appliances and oral surgery may be given only with the approval of the Dental Estimates Board established for this purpose under the National

Health Services Act 1946, and consisting preponderantly of dental practitioners. In certain cases patients wishing for treatment or appliances which are more expensive than is necessary on purely clinical grounds may have them with the authority of the Dental Estimates Board if they are prepared to pay the extra cost.

The number of dentists taking part in the general dental service in England and Wales has increased from about 9,500 in 1949 to about 11,000 today, and the number of courses of dental treatment given has risen from about 8 million to over 22 million.

General Ophthalmic Services

The general ophthalmic services form only a part of the eye services available under the National Health Service; they simply provide for the testing of sight and the supply of spectacles. Anyone found to be in need of treatment or to require any of the more unusual types of spectacles, or to be suffering from an abnormal condition of the eyes, is referred to his doctor for introduction, if necessary, to an eye hospital or a hospital eye clinic.

There are three kinds of highly qualified people working in the general ophthalmic services: ophthalmic medical practitioners, that is, doctors who test sight and prescribe glasses; ophthalmic opticians, who are not doctors but test sight and prescribe glasses, as well as supplying glasses; and dispensing opticians, who simply supply glasses to prescription. A representative of each of these professions is appointed to serve on the ophthalmic committee for the area.

There is complete freedom of choice for the patient using the service. Any ophthalmic medical practitioner or ophthalmic optician who has joined the service may be consulted, and lists of such practitioners and opticians can be seen at main post offices or the offices of the Area Health Authority. The person using these services for the first time must obtain from his doctor a recommendation that his sight needs testing, but after this he can go to any practitioner or optician without a further note.

When a person has had his sight test, which is free of charge, he takes his prescription to any ophthalmic or dispensing optician providing general ophthalmic services. The lenses of spectacles are supplied for a charge broadly equal to the cost of providing them and the applicant also pays for the frame he chooses. There is a choice of National Health Service frames at prices from 80p to £1·93, in addition to other more expensive frames for those who want them. People receiving supplementary benefits or otherwise in difficult circumstances can apply for help with these charges. For young children there is an entirely free range of specially designed children's spectacles, while older children still at school are entitled to free standard National Health Service lenses but must pay for the frames. Spectacles may be repaired or replaced partly at the cost of the services if the loss or damage is judged not to have been due to the applicant's lack of care.

Ophthalmic medical practitioners and ophthalmic opticians are paid prescribed fees for testing sight. Payment to ophthalmic opticians or dispensing opticians for the supply of spectacles includes a dispensing fee for professional service, together with the cost of the spectacles, and some addition to cover the risk of breakages.

Pharmaceutical Service

Everyone receiving treatment under the family doctor service is entitled to medicines and certain appliances prescribed by his doctor as part of that treatment. Almost all the pharmacies in England and Wales (about 11,000) take part in the National Health Service and display notices to this effect in their windows. Some special appliances may be supplied through hospitals or from specialist firms. Arrangements may also be made in certain cases for doctors to dispense drugs and appliances. The majority of dispensing, however, is done by chemists for patients who hand them a prescription from their doctor. Pharmaceutical chemists in the service are required to keep their pharmacies open at all reasonable hours, and a rota system has been worked out in most areas whereby chemists take turns to be open for an hour in the evening and on Sundays and on public holidays.

Except for certain categories of patients who are exempt (see p. 14) there is a charge of 20p for each item supplied on prescription (except for elastic hosiery, which is charged at 25p or 50p a piece).

For dispensing prescriptions under the National Health Service, chemists are paid for each prescription the cost of the ingredients, a percentage on cost, a container allowance and a professional fee.

Home Nurses, Midwives and Health Visitors

Health authorities are under a duty to provide, or to arrange for voluntary organisations to provide, home nurses, midwives and health visitors, to meet the demand of patients. Home nurses attend to people needing nursing in their homes or elsewhere outside hospitals. Midwives assist the family doctor at home confinements (nearly 7 per cent of all confinements), and care for mothers and babies (whether born at home or in hospital) for 14 days after the birth. Health visitors are concerned with the health of the household as a whole, and have an important part to play in health education and preventive measures. They work in close co-operation with general medical practitioners, the paediatric, geriatric and chronic wards of hospitals and social workers.

Group Practices and Health Centres

Increasingly family doctors are working as members of co-ordinated primary health care teams. About four-fifths of them are in partnership or group practices, and it is becoming more and more common for home nurses, midwives and health visitors to work from the larger premises established for such practices. About ten per cent of doctors now work in health centres—centres owned by the health authorities, and manned by multi-disciplinary teams of doctors, dentists, nurses, midwives, health visitors, pharmacists, social workers and others, so as to provide an all-round primary care service and in some cases consultant and other out-patient services. At the end of December 1973, 468 health centres were in operation in England, 153 were under construction and many more planned.

HOSPITAL AND SPECIALIST SERVICES

THE HOSPITAL and specialist services provide all forms of hospital care and treatment in general and special hospitals for in-patients, out-patients and day patients. They also provide specialist opinion and treatment, either in hospitals and clinics or, where this is advised, at the homes of the patients. The domiciliary consultant service has grown rapidly since its introduction at the start of the service and forms a valuable link between hospitals and general practitioners.

A blood transfusion service, a pathological laboratory service, and an X-ray service are at the disposal of every hospital. A screening service for the detection of cervical cancer is provided; hospital laboratories examine cervical smears taken at Area Health Authority and Family Planning Association clinics (see p. 26) and by general practitioners, as well as providing a diagnostic service for their own gynaecology and ante-natal and post-natal clinics. Venereal disease clinics are held at many hospitals and treatment is given confidentially so that attendance is encouraged and maintained.

The hospital service has a major role to play in the treatment and supervision of heroin addiction and other forms of drug addiction. In-patient services provide withdrawal treatment and the first stages of rehabilitation; special out-patient clinics for heroin addicts provide medical supervision for those not willing to accept withdrawal treatment.

All these services are available free to every member of the public, whether or not they use the family doctor service and irrespective of national insurance qualifications. As a general rule, they are obtained through the patient's family doctor, who makes all arrangements both for specialist advice and for hospital accommodation where this is necessary. Where medicines or appliances (including spectacles and dentures) are supplied by hospitals, any charges are on the same principles and rates as for those supplied in the general medical services, and the income from the charges is not part of the hospital income but is appropriated by the Department of Health and Social Security to help to pay for the National Health Service as a whole.

Hospital Accommodation

There are about 2,300 hospitals in England, including the 25 teaching hospitals in London (actually groups of hospitals, convalescent homes, branches, annexes and treatment centres numbering over 100 altogether), and the nine teaching hospitals elsewhere in England (comprising some 40 hospitals and other establishments). In addition there are district general Hospitals which provide a wide range of treatment and diagnostic facilities for in-patients, day patients and out-patients, and contain hospital maternity departments, children's departments, infectious disease units, psychiatric and geriatric facilities, rehabilitation facilities and convalescent homes. There are also a number of smaller local hospitals. In all, these hospitals have 404,000 beds available for use, and a nursing and midwifery staff of some 195,000 full-time and about 114,000 part-time staff.

The trend during the last ten years has been towards a more intensive use of hospital resources. Among factors contributing to this are advances in

medical techniques, equipment and materials, especially drugs; better diagnostic facilities and procedures; reduction in the length of stay of patients in hospital; and the growing effectiveness of management. The majority of patients are accommodated in general wards, but certain hospitals have beds in single rooms or small wards which, if not required for patients needing privacy on medical grounds, may be made available to patients desiring them as an amenity. In such cases the hospital makes a charge which is determined by the Secretaty of State; at present the charges in England are £2 a day for single rooms and £1 a day for beds in small wards. At some NHS hospitals a limited number of private beds are available for the use of patients who prefer to make private arrangements for their medical treatment. A patient using one of these beds pays the full cost of the accommodation and services provided and the fees of the consultant treating him. A few hospitals also have out-patient facilities for private patients.

There are a number of hospitals specially for children but the trend is towards children's departments for all sick children in district general hospitals; a selected number of which (usually teaching hospitals) have developed certain specialisations and accept cases within their special competence from the region as a whole. Children's departments comprise in-patient beds, day beds, out-patients units and comprehensive assessment centres for handicapped children. Children's departments are increasingly providing overnight accommodation for parents of young children.

Hospital Building

When the National Health Service came into being in 1948 the provision of hospitals over the country was uneven, both in quality and quantity, and many hospitals were small with limited facilities or housed in old, inconvenient buildings. A large proportion of the hospitals had been built in the nineteenth century, and some even earlier.

Scarcity of capital resources seriously limited hospital building in the early years of the service, and up to 1955 most of the works undertaken were improvements to existing accommodation. An expanded programme of new hospital building and improvements was started in Great Britain in 1956, and in 1962 the Government published long-term plans for modernising the whole pattern and content of the hospital service, involving a considerable increase in the rate of hospital building. In 1966 a revised programme for the ten-year period 1966–67 to 1975–76 was announced. Expenditure of nearly £550 million was incurred in England in the five years from 1966–67, and in the remainder of the period expenditure amounting to about £800 million at 1971 prices was anticipated. Some retardation of the programme was, however, caused by the economic difficulties of the winter of 1973–74 and by the announcement by the Chancellor of the Exchequer on 17 December 1973 that there would be reduction in public capital expenditure.

The capital programme has been extended following the NHS reorganisation and now includes the provision of health centres, ambulance services, etc, previously undertaken by local authorities, as well as hospital building. Capital expenditure on the health capital programme in England is expected to be about £240 million in 1974–75.

Under the programme a network of district general hospitals, each with a

wide range of diagnostic and treatment facilities, is to be established by building new hospitals and remodelling existing ones. Special attention is being given to the needs of geriatric and psychiatric patients. At the same time it has been decided that there will continue to be an important function for smaller local community hospitals closely linked with primary health care. In addition to the funds provided by the Government, some additional funds for hospital extensions and improvements come from voluntary sources.

The health departments (the Department of Health and Social Security in England) issue Hospital Building Notes, Equipment Notes and other guidance material to assist health authorities in the planning of hospital developments. Standardised building components are in use to some extent and experimental building schemes are conducted to test how economically a hospital can be planned and built.

Beds and Treatments

The building programme has been aimed at increasing the efficiency as well as the capacity of the hospital service by replacing some of the more old-fashioned buildings by new hospitals designed to make possible the most intensive and effective use of medical resources, both technical and human. This has been one of the key factors, which has led to the speeding up of treatment and the more effective use of beds. The average stay which patients make in hospital has been shortened, and the number of patients treated as in-patients in National Health Service hospitals in England and Wales had increased to 5·2 million by 1972, nearly 30 per cent more than in 1960, although the total stock of hospital beds had actually been falling.

Rehabilitation

The importance of rehabilitation as a facet of medical treatment is firmly established, and today hospital treatment does not stop at relief of pain, or alleviation or cure of pathological conditions, but aims at helping people to resume normal living as soon as possible. Special rehabilitation facilities are provided, for those requiring them, in the departments of physical medicine and occupational therapy at the main hospitals, and at some special rehabilitation centres which are not attached to any hospital. The work is carried out under the guidance of the appropriate medical specialists by physiotherapists, remedial gymnasts, occupational therapists and social workers, working as a team. Experience has shown that efficient medical rehabilitation reduces the stay in hospital, the incidence of permanent disability and the period of incapacity for full work. The hospital departments have accordingly worked in close association with the Disablement Resettlement Service of the Department of Employment, and will continue to work with this service after its reorganisation as from 1 October 1974 as part of the Employment Services Agency. Rehabilitation methods have been applied with advantage in the care of the chronic sick, the aged and the handicapped, and have enabled many to become self-sufficient or to be discharged from hospital to resume an independent life in their own homes. Recent reports have pointed out that rehabilitation facilities are unevenly distributed and need further strengthening and co-ordination.

MOTHERS AND CHILDREN

THE Area Health Authorities have since 1 April 1974 taken over responsibility for maternity and child health services, including the community health services previously administered by local authorities and the medical and dental inspection and treatment functions of the school health services formerly provided by local education authorities. The community health services include a network of maternity and child health centres, the more recent of which have usually been built as part of all-purpose health centres.

Maternity Services

When a woman thinks she is pregnant it is usual for her to consult her family doctor for examination and advice and to decide about the place of confinement. The doctor will explain the reason why all women with the slightest risk of complications should have all the resources of a fully equipped maternity hospital readily available to them and their babies. If the doctor finds that the woman's medical and obstetric history is satisfactory and that the home is suitable he may agree to attend her in her own home or advise her to consult one of his colleagues on the obstetric list (a list of family doctors recommended by the local Obstetric Committee—a purely professional body—by virtue of their knowledge of pregnancy and childbirth). More and more women (about 92 per cent in England and Wales) wish or need to have a hospital confinement, but most of them like to return to their own homes soon after the birth.

A woman selected for home confinement is looked after by the domiciliary midwife and the doctor. The midwife gives her share of ante-natal care, sometimes at her own or the mother's home, sometimes at the doctor's surgery where he holds special ante-natal sessions, or at the maternal and child health centre where supplementary advice and other facilities are available. If there is any deviation from normal ante-natal progress in a woman booked for home delivery the doctor may request hospital consultant advice.

If admission to hospital is preferred or necessary on medical and obstetric grounds the family doctor makes the arrangements directly with the hospital consultant. In certain areas hospital beds are made available for use by the general practitioner who wishes to continue caring for the patient throughout confinement. In some cases the hospital may share some of the ante-natal care with the patient's own doctor. Much thought is given to good human relationships and to the creation of a home-like atmosphere in the maternity ward. The post-natal stay in hospital is now about six days; some 17 per cent to 18 per cent of women are discharged home within 48 hours of delivery to the care of the family doctor and domiciliary midwife.

There are about 22,000 maternity beds in England, of which about 17,000 are consultant beds and nearly 5,000 general practitioner beds with a consultant obstetrician having overall responsibility. About 90 per cent of all expectant mothers are confined in National Health Service hospitals. The ante-natal care of patients hospital-booked or booked on specialist advice cases is usually undertaken in the hospital, but in many instances some or

all of the ante-natal care is given by the family doctor and domiciliary midwife at the request of the hospital. If a family doctor finds that a patient for whom he has elected to provide maternity services requires specialist advice he can refer her at any time to the hospital for consultation or admission. At the hospital, specialist services, including laboratory and X-ray facilities, are readily available. The major maternity hospitals provide an emergency obstetric service staffed by a consultant obstetrician or a senior obstetric registrar for emergencies in the domiciliary service or in the small peripheral maternity hospitals.

While the midwife will continue to attend the mother and baby as long as she is needed, she may at any time after the confinement advise the health visitor that her services would be helpful. The health visitor will in any event call on the mother in her own home, as soon as the midwife's task is completed. She is specially trained to advise mothers on the care of their young children. One of her particular concerns is to seek, in collaboration with her medical colleagues, the earliest possible identification of infants likely to develop mental and physical handicaps, so as to ensure that necessary treatment is instituted promptly and the child's full potential safeguarded. She will also be in attendance at the maternal and child health centre (and in some areas in the family doctors' surgeries) where the majority of mothers take their babies for advice on all matters affecting the baby's health and welfare.

About six weeks after the birth of the baby the mother is given a post-natal examination by the hospital if she received her ante-natal care there, or by the doctor who has given her ante-natal care under the maternity medical services, to confirm that she has returned to normal health and activity.

Every effort is made in normal circumstances to safeguard the life of both the mother and unborn child. The circumstances in which a doctor is justified in terminating a pregnancy are defined in the Abortion Act 1967, the purpose of which was to amend and clarify the law relating to abortions so that the operation could legally be performed where certain criteria were met. The Act, which came into effect on 27 April 1968, states that a doctor may terminate a pregnancy if two registered medical practitioners are of the opinion, formed in good faith:

(a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or

(b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in (a), account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

The Act further allows termination by a registered medical practitioner where he is of the opinion that the termination is immediately necessary to save the life of the woman or to prevent grave permanent injury to her health, without requiring the recommendation of a second doctor. The Act also requires that, such cases of immediate necessity excepted, a termination

should be carried out in a state hospital or in a private nursing home approved for that purpose by the Secretary of State. The woman's age, marital status, duration of pregnancy, previous obstetric history, any complications consequent on the operation, and whether a sterilisation was performed have to be notified to the Chief Medical Officer at the Department of Health and Social Security within seven days of the operation.

Family Planning

NHS family planning clinics and hospitals provide a family planning service to all, irrespective of age, sex or marital status. Advice is free, as are supplies prescribed and dispensed.

Advice is also available from general medical practitioners. At the time of going to press, negotiations with the medical profession on the terms on which general practitioners will prescribe for non-medical cases under the NHS were not yet complete. In cases of medical need to avoid pregnancy, the normal NHS prescription charge (subject to the usual exemption) was payable for any supplies dispensed. Otherwise the doctor might charge for writing the prescription and the full cost of supplies had to be paid.

Pre-School Children

In addition to the services provided by family doctors, a network of child health centres provide facilities for the regular and systematic supervision of children's physical, mental and emotional health and development by doctors, dentists and health visitors, many with additional training. An important function of the services of centres is to provide advice and health education on all matters connected with the health of pre-school children, such as nutrition and dental care.

Health education is also provided both formally and informally in the home, at general practitioner premises, community centres and in hospitals. The health visitor has a special role in caring for the health of pre-school children by visiting parents in their own homes, to advise them about their child's health and development and to tell them about the child health services which are available and to encourage their use.

School Health Services

Area Health Authorities are responsible for the medical and dental inspection and treatment of school children, for which the Secretary of State is required to make provision under Section 3 of the NHS Reorganisation Act 1973.

The purpose of school medical inspections—made by doctors with special knowledge and experience of conditions likely to interfere with normal learning—is to identify as early as possible any departure from normal, to ensure that appropriate advice and treatment is being obtained and to advise the local education authority, the school, the parents and the pupil of any health factors which may require special consideration during the pupil's school life. Children are medically inspected as soon as possible during their first year at primary school or, if they are inspected immediately before entering primary school, they are examined again after they have had time to settle into school.

Practice for subsequent medical examination varies. In place of subsequent

periodical general medical inspections it is becoming the practice for school doctors to visit schools several times each term and see children brought to their attention by parents, teachers and school nurses. The purpose of greater selectivity is to increase the effectiveness of the preventive work of the school health services, enabling the staff to work in close consultation with teachers and facilitate general observation of children in the school environment. This more selective system may be combined with a periodic examination of all pupils during the secondary stage. The aims of the school dental service are to provide inspection on school entry and, as far as resources permit, annual re-inspection and the provision of necessary treatment, either in the school dental service or in the general dental services.

Inspections are normally carried out on school premises and it is the responsibility of the local education authorities to make such accommodation available.

School clinics provide for treatment and advice, as the need arises, about specific medical and dental problems associated with children of school age, offer dental treatment and facilitate treatment of minor ailments. There are also arrangements for the testing of sight and hearing and the free supply of spectacles and hearing aids, including behind-the-ear hearing aids.

Handicapped Children

Although the Area Health Authority's responsibility for medical inspection and treatment of school children extends to handicapped children in special schools, responsibility for the ascertainment of pupils needing some form of special educational treatment has remained with local education authorities. However, suitably experienced medical staff, made available by Area Health authorities, advise local education authorities on the medical aspects of a child's need for special education. In the case of educational subnormality it is a legal requirement that such medical advice is given by a doctor who has undergone an approved course of special training.

School health services are available in all special schools—where it is particularly important that teachers understand the medical problems of handicapped pupils and that medical and other health staff should understand their educational problems. In boarding schools the additional medical requirement of general medical services for children living away from home is provided by a local general practitioner.

Many children both in special and ordinary schools need the services not only of doctors but also of other health staff. To meet these needs Area Health Authorities provide the services of nurses and dentists and other staff such as physiotherapists and speech therapists. Some of these staff attend special schools from time to time as needed, as is the case with ordinary schools, whilst others work there whole-time in close collaboration with teaching and other health staff.

Hospital and Specialist Services for Children

Whenever possible sick children are treated in their own homes under the care of the family doctor, with the support from other members of the primary health care team, from the hospital and specialist services and from the personal social services. Even when the medical and dental treatment require-

ments of some children can be provided only in a hospital, increasingly investigations and treatment, including certain surgical operations, are carried out on a day basis. When hospital admission is unavoidable for the child the aim is to care for him with other children in a children's department with a consultant paediatrician having general oversight of the welfare of all children and where he will be nursed by those experienced in child development and in the special needs of children and in the techniques for caring for sick children. Every effort is made, especially for long-stay child patients, to ensure that adequate links with home and family are maintained and that the children are given as full and happy a life as possible. Unrestricted visiting facilitates this. Parents of young children are encouraged to stay in the hospital with their children during acute illness, during comprehensive assessment, and from time to time during long-stay care. There are arrangements by which all children in hospital can continue education, and great attention is paid to organised play with the advice of experts.

THE ELDERLY, THE CHRONIC SICK AND THE DISABLED

NEARLY 20 per cent of the population of Britain are over 60, and about 13 per cent are over 65. Though most of these elderly people live healthy and active lives, a substantial proportion—estimates vary from 20 per cent to 40 per cent according to the definitions used—have some chronic illnesses, impairment or infirmity. The proportion thus affected and the general need of medical services increase fairly steeply with age. The commonest afflictions are arthritis and rheumatism; heart-disease and hypertension; and bronchitis. About 1 million elderly people are severely or appreciably disabled. Almost a half of Britain's general medical and psychiatric hospital beds, and a third of the surgical are occupied by the elderly, who also take up a correspondingly high proportion of general practitioners' time.

In addition to the elderly there are probably between 1 million and 1·5 million other people with some chronic illness, disability or infirmity, about a third of whom are severely or appreciably disabled.

All these elderly, chronic sick and disabled people constitute a vast medico-social problem which is being tackled by the health and social services together. Most of them are cared for at home with medical advice and help from the primary health care services, and often also help from social workers on linked social problems and some financial support from social security funds. At any one time, however, a large number are being treated in hospital either as in-patients, day patients or out-patients. Increasingly elderly patients with multiple medical problems are being treated in special geriatric units of district general hospitals. Such units provide for the assessment and immediate treatment of patients admitted (including in many areas joint assessment by geriatric physicians and psychiatrists of those patients with both mental and physical disorders) and for their rehabilitation to prepare them for discharge home. Beds for patients requiring longer stay may be provided at a general hospital, or at an associated smaller hospital serving a local community. Patients suitable to the smaller hospitals are those who require rehabilitation on a less intensive scale, or those who have not responded, or who are unable to respond to efforts of rehabilitation, but continue to need professional care beyond that which the family or residential home could normally be expected to provide. Beds in small local hospitals serving a community are also considered appropriate for patients who are in the latter stages of a terminal illness, or those who have been admitted to afford their families temporary relief.

Although these arrangements are not yet fully available in all parts of Britain, the provision of geriatric units is receiving special priority under current hospital development plans. The effects of the new approach are reflected in the more rapid recovery and discharge of elderly and chronic sick patients. The average length of stay in geriatric and chronic sickness wards in England and Wales fell from 272 days in 1962 to 112 in 1972.

Increasingly in the past decade day hospitals have been used for rehabilitation of the elderly who have been ill, or for the active treatment and supervision of people who need help to maintain or restore their independence.

In 1972 there were 867,000 attendances at such hospitals in England and Wales, compared with 61,000 in 1961. Patients, including some hospital in-patients nearing discharge, attend the day hospitals for the whole day for physiotherapy and occupational therapy, as well as for medical treatment, and for instruction in the use of aids for the handicapped.

Elderly, chronic sick or impaired people may also attend hospital out-patient clinics for diagnosis or for treatment. This may follow a period of treatment as an in-patient and continue the specialist supervision and care with the minimum interference with ordinary life. Many disabilities are treated in out-patient clinics. Elderly and handicapped patients may attend physiotherapy classes, learn to use appliances or artificial limbs, or attend eye or ear clinics.

MENTAL ILLNESS

TREATMENT for mental disorder is provided as part of the National Health Service. Patients can consult their family doctor and receive specialist advice at hospital out-patient clinics as they would for any other illness. They can enter hospital for in-patient treatment informally.

Where necessary in the interests of society or of the patients themselves, mentally disordered patients can be compulsorily detained in hospital. Compulsion is regulated in England and Wales by the Mental Health Act 1959. A major aim of the Act is that, as far as possible, mental disorder should be dealt with in the same way as other kinds of illness and that compulsory powers should be used only where quite unavoidable, for the good of the patient and those with whom he is in contact. In England only 6 per cent of mental patients in hospital were compulsorily detained at the end of 1972. There are procedural safeguards to protect the patient from unnecessary detention, and he, or his relatives, may appeal against detention to a mental health review tribunal, an independent body appointed by the Lord Chancellor.

With the more rapid and effective treatments now available, the main role of the hospital is no longer to provide long-term asylum but treatment and preparation for return to life in the community. The length of in-patient stay has been much reduced and consequently, although in England and Wales in-patient admissions to mental illness hospitals increased from 67,000 in 1953 to 185,000 (175,000 in England only) in 1972, the number of beds fell from 156,000 to 121,000.

Increasing emphasis is being placed on out-patient and day-patient treatment. The number of new out-patients rose from 127,000 in 1953 to 226,000 in 1972, and the number of day patients from virtually nil to 29,000. At the end of 1972 there were 136 mental illness hospitals. Many of these are old and unsuitable for modern standards and the department is aiming at their replacement—in many cases by departments in general hospitals. This will take some time but by the end of 1972 there were already 124 such departments including those in teaching hospitals. The number of consultant psychiatrists in England and Wales increased by 80 per cent in the 12 years from 1960 to 1972.

OCCUPATIONAL HEALTH

OCCUPATIONAL health services are essentially preventive and protective. They constitute in effect an extension of the public health services into places of work and, like them, are complementary to the personal health services. In addition to the relevant sections of the Public Health Acts (see p. 12) there are a number of enactments concerned with setting health, as well as safety and amenity, standards in places of work and providing inspection and enforcement. Among the more important of such Acts are the Factories Act 1961, the Mines and Quarries Act 1954, the Offices, Shops and Railway Premises Act 1963 and the Health and Safety at Work etc. Act 1974.

The laws restricting the employment of children, young persons and women form another important part of protective health legislation. In addition, a number of employers voluntarily maintain medical services for their employees over and above the statutory requirements.

Health and Safety at Work etc. Act 1974

The Health and Safety at Work etc. Act 1974 has established a legal framework for the comprehensive protection of employees. It makes provision for protecting the health and safety of virtually all people at work and members of the public where they may be effected by work activities, and establishes a Health and Safety Commission and executive responsible to ministers for administering the legislation. It places general duties on everyone concerned with health and safety at work, confers on the Secretary of State for Employment powers to make regulations dealing with particular hazards to health and safety and provides for the commission to issue codes of practice for improving standards of protection of employees and the public. In particular the Act empowers inspectors (see below) to issue prohibition and improvement notices, requiring preventive measures immediately or improvements within a specified time.

The Health and Safety Commission

The Health and Safety Commission and its executive carry out functions previously the responsibility of various ministries. The commission consists of a chairman and several other members appointed after consultation with employers' and employees' organisations, local authorities and others, and is generally responsible for the work of the executive, which can enforce statutory requirements on safety and health (see below) and comprises mainly the formerly separate Government inspectorates covering factories, mines and quarries, explosives, nuclear installations and alkali works.

The commission also has a major research, education and advisory role.

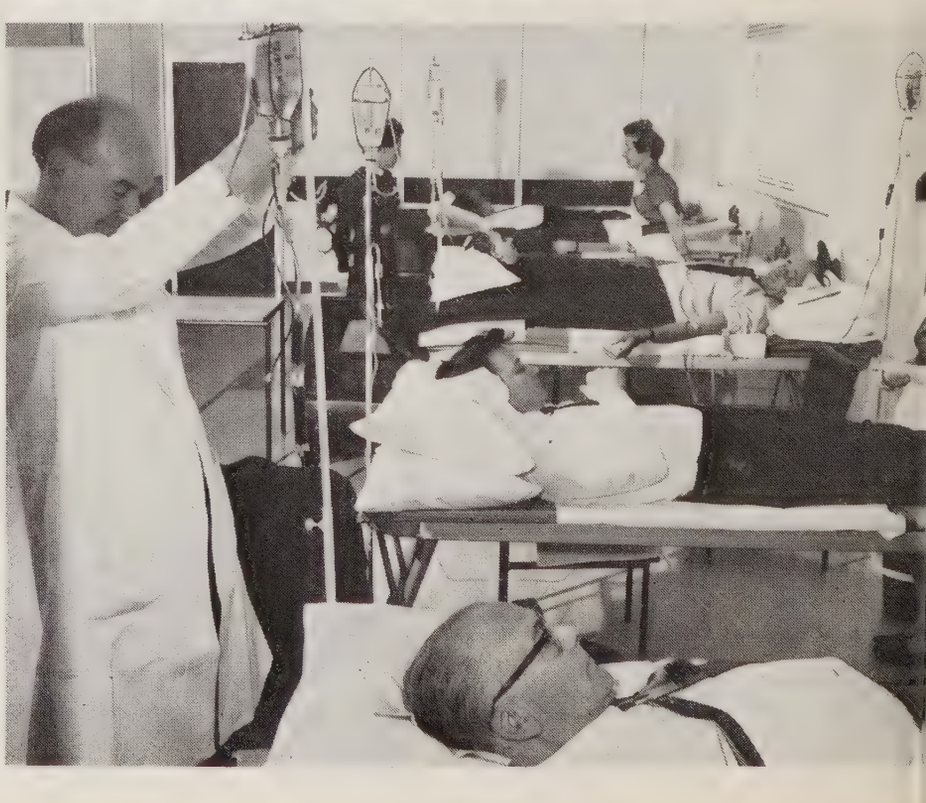
To secure the voluntary co-operation of managements and employees in individual workplaces, the Health and Safety at Work etc. Act 1974 provides for the appointment of trade union safety representatives and safety committees. Most large and many small firms have works safety committees and safety officers, and in many areas safety groups (discussion groups with members from different firms) have been organised.

The new Charing Cross Hospital in Fulham Palace Road, London, built under the programme to replace and modernise old hospitals.

Below: The Renal Unit at Belfast City Hospital.

The Dental Department at Greenwich District Hospital in south-east London, which is among the hospital's facilities for out-patients.

Below: Occupational therapy in a psychiatric hospital.



Regional Transfusion Centre, Liverpool. Voluntary blood donors receiving the return of their red blood cells, after the plasma has been extracted.

Above: The health centre on pillars at Thamesmead, the Greater London Council's development near the south bank of the River Thames at Woolwich and Erith.

A mobile health clinic at Erith, Kent.

A specialist doctor at a Family Health Clinic examines a six-year old. Children's spectacles are provided free under the National Health Service.

Below: Laboratories of the Employment Medical Advisory Service. Blood samples from lead industry workers are being examined.

A group of student nurses attending a lecture.

Medical Advisory Services

There are special arrangements for the medical care of people at work. A medical practitioner is obliged under the Factories Act (see below) to report to the Chief Inspector of Factories details of cases where he believes the patient to be suffering from a disease contracted in any factory. The former Appointed Factory Doctor Service, which dealt mainly with the periodic medical examination of young people in industrial establishments and of workers in certain hazardous occupations, was replaced in 1973 by the Employment Medical Advisory Service (EMAS), under the Employment Medical Advisory Service Act 1972. The service provides advice on the medical aspects of employment problems to employers, employees, trade unions, doctors and others. In particular it carries out the periodic medical examination of workers in hazardous occupations as required under factories legislation, and, in conjunction with school medical officers and career officers, advises young people who are starting work and whose school medical records reveal a need for special care in choice of employment. In addition the service encourages the voluntary provision by employers of industrial health services. Public undertakings and many private employers, especially large and medium-sized firms, have appointed industrial medical officers and/or industrial nurses for the supervision of the health of their workers. It is estimated that there are about 400 factories with doctors providing full-time medical cover and about 4,000 factories with part-time medical cover. Several thousand nurses are also employed in industry.

In addition to safeguarding health at work by preventive action, industrial medical officers and industrial nurses provide on-the-spot medical care and first-aid treatment.

Where a firm is too small to equip itself with such a service alone it is possible, by combining with other firms in the locality, to operate a joint service. Group services are operating in Slough, Harlow, Rochdale, Dundee and West Bromwich, and another is attached to the Central Middlesex Hospital.

Premises under the Factories Act

About 250,000 industrial premises—factories, workshops, shipyards, docks and construction sites—in Great Britain are covered by the Factories Act 1961, which consolidated earlier Acts reflecting over a century of factory legislation. The Factories Act is enforced by the Factories Inspectorate, now part of the Health and Safety Executive.

Under that Act anyone intending to use premises as a factory has to give the district inspector of factories a month's notice of his intention; and every fatal accident and every accident causing more than three days' absence from work must be reported to a factory inspector. The Act lays down general requirements for safety, health and welfare and give the Secretary of State for Employment power to make regulations for particular industries and processes.

The normal hours worked by women and young people under 18 in premises covered by the Factories Act are limited to 48 hours a week (44 for the under-16s) and 9 a day, and must normally be between 7 am and 8 pm (6 pm for the under-16s) or 1 pm on Saturdays. Women and young

people must not work longer than $4\frac{1}{2}$ hours without having at least a half-hour break (5 hours if a ten-minute break has been allowed within that period). Pressure of work may be met by overtime done by women and young people over 16 only up to 6 hours in one week and 100 hours in any one calendar year. In practice, the hours worked by adult men also usually fall within the legal limits for women and young people.

Nuclear Installations

The Secretary of State for Energy is responsible under the Nuclear Installations Acts for granting site licences for nuclear installations and for laying down any conditions necessary in the interests of safety. The Nuclear Installations Inspectorate is responsible for questions of health and safety in nuclear establishments subject to the Factories Act. Provisions for the safety of people whose occupations involve contact with, or exposure to, radioactive substances or irradiating apparatus are also contained in the Radioactive Substances Act 1960, and the Health and Safety at Work etc. Act 1974 provides for consultation between the Health and Safety Commission and the National Radiological Protection Board, established in 1970 to provide an authoritative point of reference in Britain on radiological protection.

Mines and Quarries

Protective legislation for the safety of workers in mines and quarries began with an Act of 1842, which forbade the employment of women underground. The most recent special legislation is embodied in the Mines and Quarries Act 1954 which established the basic modern principles of safety and health; the details are set out in statutory regulations. Apart from technical matters, it covers such subjects as the general responsibilities of owners and managements, the appointment and duties of officials, training, welfare, the power of official inspectors, statutory qualifications of managers and undermanagers and inspection. The Mines and Quarries Inspectorate under the Health and Safety Executive is responsible for enforcing these enactments.

In coal-mining, the National Coal Board has a statutory duty to secure the safety, health and welfare of its employees.

Offices, Shops and Railway Premises

About 750,000 premises in Great Britain come under the Offices, Shops and Railway Premises Act 1963. This is enforced by the larger local government authorities (which are concerned with most office and shop premises), the Factory Inspectorate (concerned with the application of the Act to railway premises and offices and shops on factory premises) and the Mines and Quarries Inspectorate (concerned where an office or shop operates at a mine or quarry).

Under the Act, anyone employing or intending to employ workers in office, shop or railway premises has to notify the authority responsible for enforcing the Act; and every fatal accident and every accident causing more than three days' absence from work (as in factories) must be reported to the same authority. The Act lays down general requirements for safety, health and welfare. These are supplemented by subordinate legislation

prescribing details or providing for the needs of particular industries or processes.

The Health and Safety at Work etc. Act 1974 amends the Fire Precautions Act 1971 to allow for the transfer to fire authorities (that is, local authorities responsible for the fighting and prevention of fire) of responsibilities for general fire precautions and means of escape in offices and shops, factories and mines and quarries.

The hours of work of employees under 18 in shops are limited in Great Britain, under the Shops Act 1950, to 48 hours a week (44 for the under-16s). The hours of employment of young people in a number of other commercial occupations such as errand boys, lift boys and van boys, are limited under the Young Persons (Employment) Act 1938.

Agriculture

Two Acts—the Agriculture (Poisonous Substances) Act 1952 and the Agriculture (Safety, Health and Welfare Provisions) Act 1956—enable the ministers concerned with agriculture to make regulations for the protection of agricultural workers. These regulations, which continue to be enforced separately under the Health and Safety at Work etc. Act 1974, are enforced by inspectors of the agriculture departments.

Transport

General safety legislation covering the main forms of transport protects transport workers, as well as members of the public, against accidents involving moving vehicles and hazards arising from the transport of radioactive materials. The detailed regulations and instructions form the basis of elaborate safety procedures laid down by the operators themselves and the makers of vehicles, equipment and plant. The Merchant Shipping Acts cover in great detail not only marine safety but such matters as the engagement and discharge of seamen, the employment of young people at sea, crew accommodation, provisions, medicines and medical stores, and the care and repatriation of seamen left at ports abroad. The Railway Employment (Prevention of Accidents) Act 1900 and the regulations made under it enable the Secretary of State for the Environment (who is also responsible for the Building Regulations) to require the use of safe plant and appliances, to forbid what is unsafe and to make rules for safe railway operation. There are railway employment inspectors to investigate the more serious accidents to employees, as well as railway inspectors responsible for approving new works and investigating accidents generally.

Requirements for safety equipment in aircraft, safety procedures during take-off, flight and landing, and provisions for the registration of aircraft and issue of certificates of airworthiness and competency certificates and licences for air-crew are governed by the Air Navigation Order and Regulations, which are enforced by the Civil Aviation Authority.

HEALTH SERVICES IN WALES

HEALTH services in Wales are established in accordance with legislation also covering England, notably the National Health Service Reorganisation Act 1973; and are organised on similar lines though the legislation and the arrangements made under it provide for certain significant differences to meet the special circumstances and needs of Wales.

In the first place, the Secretary of Wales is responsible for Health Services in Wales and the eight Area Health Authorities with areas conterminous with the new counties report direct to the Welsh Office, which supplies central guidance. Intermediate regional authorities were felt to be unnecessary in view of Wales' small size. A Welsh Technical Services Organisation provides necessary supplies and technical assistance to the area health authorities. The Secretary of State receives strategic advice on general health matters affecting Wales from the Welsh Council though on technical and organisational matters he is advised by the Central Health Services Council, which covers both Wales and England. The responsibilities for public health are divided between local authorities, health authorities and the water authority (the Welsh National Water Authority) in the same way as in England.

Certain services continue to be provided by departments or organisations with a wider coverage than Wales. The Central Health Services Council, the Clean Air Council, and the National Water Council are on an England and Wales basis. Industrial Health Services are on a Great Britain basis. The Medical Research Council and the registering bodies for doctors, dentists, nurses and other professions are on a United Kingdom basis.

HEALTH SERVICES IN SCOTLAND

THE DEVELOPMENT of health services in Scotland has followed a rather similar course to that in England, though it has taken place against a different legal and administrative structure and through separate legislation. In both countries the services have evolved during the past hundred years from measures for the prevention of the outbreak and spread of disease into measures for community welfare and for the care of the individual.

A reorganisation of Scottish Health Services, broadly similar to that in England and Wales, took place simultaneously under separate legislation replacing the existing tripartite organisation by an integrated structure. The National Health Service (Scotland) Act, which came into force on 1 April 1974, is very closely akin to the corresponding Act for England and Wales, although there are some administrative differences due to the somewhat different background against which the service operates.

Central responsibility for the National Health Service as a whole continues to rest with the Secretary of State for Scotland, who is advised by the Scottish Health Service Planning Council consisting of members appointed by each health board (see below) and each university with a medical faculty, as well as a chairman and other members (including six members of the central department, the Scottish Home and Health Department) appointed by the Secretary of State. Standing committees of that council have been set up in connection with particular parts of the service; these include the additional members necessary to cover particular subdivisions of the expert field.

The main operational agencies in the new structure are the 15 health boards, corresponding in function to the Area Health Authorities in England and Wales, but like the AHAs in Wales receiving guidance direct from the central department. In Scotland, because of its relatively small population, an intermediate tier of authorities, corresponding to the Regional Health Authorities in England was felt to be unnecessary.

Outside the Greater Glasgow Region, the areas covered by health boards correspond with those of the new regional and island authorities to be responsible for local government in Scotland after the beginning of May 1975 when the reorganisation of local government takes place. The Greater Glasgow Region is split between four health boards, which, even so, cover large populations. As in England and Wales the actual day-to-day operation of health services is deputed by most health boards to district management teams, though boards covering relatively small populations may choose to dispense with such delegation. To provide those services which can be most efficiently and economically organised on a national scale, there is a common services agency, employing some 6,000 people, under the control of a management committee appointed by the Secretary of State. Among its functions are the ambulance service, the blood transfusion service, dental estimates, prescription pricing, legal advice and assistance to the health service, planning and professional advice in regard to hospital and other health services building, research and intelligence, health education and some scientific services.

To represent the interests of the public and to report on questions relating to health services in their areas or district, local health councils are being set up by the health boards.

In addition there are local and national consultative committees of the health care professions broadly similar to those in England.

As an important safeguard for patients and others the National Health Service (Scotland) Act 1972, like the corresponding legislation in England and Wales provided for an 'ombudsman', the Health Service Commissioner for Scotland, to investigate complaints concerning the health services (see p. 6).

Public Health Services

The development of the public health services in Scotland has been largely on the same lines as in England, although these services have been based on separate Acts, and different authorities are responsible for the various services. In Scotland the basis is the Public Health (Scotland) Act 1897 and the Burgh Police (Scotland) Act 1892.

The local authorities at present concerned in Scotland are the councils of counties and burghs. The county councils and large burghs (that is, burghs with a population of 20,000 or more) have since 1930 been the public health local authorities for all the major public health services. The county councils are also responsible for these services in the small burghs, but certain functions may be delegated to them. The small burghs are responsible for local sanitary services, housing and some other services.

Powers similar to those exercised by the Secretary of State for the Environment under the Water Act 1945 and the Rivers (Prevention of Pollution) Act 1951 and 1961 have been conferred on the Secretary of State for Scotland.[1] The authorities concerned in Scotland with water supply and distribution are regional water boards, whose members are drawn from town and county councils; and water development boards, who supply water in bulk to the regional water boards. The local authorities for sewerage purposes are the county councils and the town councils of all burghs. These authorities also have powers under the Flood Prevention (Scotland) Act 1961 to carry out work for the prevention and mitigation of flooding of non-agricultural land. The duty of promoting the cleanliness of rivers rests on river purification boards and some large local authorities in the Highlands.

In Scotland port health control is operated by all county councils and large burghs with seaboards, which are the responsible authorities. There is only one specially constituted port local authority.

The provisions of the Clean Air Act 1956 apply also in Scotland, and by September 1973 domestic premises, industrial premises and other (including commercial and office) premises were covered by smoke control orders. A separate inspectorate operates under the Alkali, etc. Act of 1906.

Local authorities in Scotland have responsibilities for housing similar to those of the English authorities. Their powers are mainly derived from the Housing (Scotland) Act 1966. The Scottish provisions with regard to the conditions of housing accommodation are similar to those for England and Wales (see p. 9).

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[1]By the Water (Scotland) Acts 1946 and 1967, the Rural Water Supplies and Sewerage Acts 1944 to 1955 and The Rivers (Prevention of Pollution) (Scotland) Acts 1951 and 1965.

The Secretary of State for Scotland is concerned in the central administration of the legislation relating to food and drugs.

Under the new local authority structure of 9 regions, 3 island authorities and 53 districts due to come into operation in May 1975, regional authorities will deal with strategic planning, including water supply and sewage disposal for which they will also assume operational responsibility, but most other public health responsibilities will be left to the districts. Island councils will be unitary multi-purpose authorities, not subdivided into districts. Liaison between Scottish area health boards and both the present and future local authorities will be maintained in the same sort of way as in England (see p. 8).

Primary Care

The development of primary care has in general proceeded on lines similar to those in England and the pattern of primary health care for the future will increasingly be based on health centres throughout Scotland rather than on a series of separate surgeries and clinics.

At January 1974, 51 health centres were in operation in Scotland. Some 400 general practitioners practised from these health centres. Twelve of the centres were sited within hospital grounds or were within the same building as the hospital, while hospital services were provided at 13 other centres. A further 20 health centres were under construction, 15 more were at the rental or tendering stage, plans for another five had been approved and plans for a further 18 were under consideration. An additional 80 centres were at earlier stages of consideration.

The building programme really began to have an impact in 1971, when there was a rapid acceleration in the completion of centres. Capital expenditure on health centres in 1972–73 was £1 million. A striking feature of the programme has been the emergence of larger, complex centres. The first of these, at Woodside in Glasgow, serves a population of some 45,000. In 1973 the largest centre yet included in the programme started operating at Clydebank, where a population of 60,000 to 70,000 are served by 30 general practitioners. Large centres are also planned at East Kilbride and Dumbarton.

As a result of the programme, it is expected that more than half of the Scottish population will be cared for from health centres by 1980. By the mid-1980s it is hoped that the major part of the programme, covering 80 per cent of the population, will be completed.

Hospitals

The Scottish hospital system is based on the same general plan as the English—district general hospitals backed by smaller community hospitals and some specialist hospitals.

The basis for Scotland's current hospital building programme goes back to a 1966 review of the hospital plan for Scotland. This gave priority to 35 major schemes up and down the country. Of these 18 have now been completed, 13 are in the course of building and 4 are at the planning stage.

An extension of the programme of major hospital building projects was announced in 1970, when future schemes were listed in four priority bands denoting the order in which they would be planned to start. In 1972 two

more bands were added to the programme, reflecting the importance attached to long-stay psychiatric and geriatric provision. These two bands extended the actual building programme well into the 1970s.

The value of all hospital building work in progress in Scotland at the end of 1973 was £116·83 million. During the year work to the value of £7·45 million was completed. This brought the total value of work completed between July 1948 and December 1973 up to £137·65 million.

HEALTH SERVICES IN NORTHERN IRELAND

THE SERVICES provided under the Health and Personal Social Services (Northern Ireland) Order 1972 correspond fairly closely to the system under the National Health Service in Great Britain and are financed in the same way as in the rest of the United Kingdom.

From 1 October 1973 the former tripartite arrangement for the provision of health and personal social services was replaced by a unified structure in which these services are provided by four health and social services boards acting as agents of the Department of Health and Social Services. The services provided include hospital and specialist services, practitioner and other primary health care services and personal social services. The boards have under their control 94 hospitals containing in all about 18,000 beds. There are some 747 general practitioners (with an average of 2,102 patients each), 319 dentists, 116 ophthalmic medical practitioners and ophthalmic and dispensing opticians.

Each of the boards administers an area conterminous with a group of the 26 new local government districts and each is divided into districts which have populations of 50,000 to 100,000 except for those under the Eastern Board, where these figures are more than doubled. District executive teams run the districts but, unlike the English, district management teams are directly responsible to area management teams. There are programme planning teams at area level as opposed to the district health care planning teams in England. District committees correspond to the English ones.

Two further important differences from the English model are that in Northern Ireland general practitioners are in contract with the boards and that personal social services have been brought under a unified administration with health separately from local authorities.

A central council advises the Department of Health and Social Services on overall policy, while a consortium of the boards, the Central Services Agency, deals with services and other matters best organised centrally.

MEDICAL RESEARCH

THE EXTENSION of medical research, particularly in the last 50 years, has been a prominent factor in the improvement in the health of the population.

New knowledge, new drugs and new methods of treatment have led to the virtual elimination of diseases such as diphtheria, smallpox and pneumonia, which formerly accounted for a high proportion of deaths, as well as to the alleviation of pain and suffering generally. Accordingly the emphasis in modern research has moved to chronic diseases and in particular to cancer, coronary heart disease, diabetes, rheumatism and mental illness; to fundamental studies in other sciences bearing on the nature of living matter; and to the health hazards presented by new technologies, such as those associated with nuclear energy or with the progress of medicine itself. For example, viruses and bacteria develop strains resistant to known drugs, and new means to combat them must be continuously sought.

Government funds for medical research in Britain are channelled through the University Grants Committee whose general grants to universities cover research as well as teaching; the Medical Research Council, which administers four research institutes and numerous research units as well as providing grants for research teams and individuals; and the health departments which support research in aid of the National Health Service in universities, hospitals, other Government departments and industry. There are also health aspects to some research for defence purposes. Further support is provided by the World Health Organisation and by a large number of charitable foundations and organisations, such as the Cancer Research Campaign and the Nuffield Foundation; and there is substantial investment in medical research and development by the pharmaceutical and medical equipment industries.

Expenditure by the Government on medical research was of the order of £108 million in 1972–73. This included £25 million devoted to medical research out of the grants made to universities on the advice of the University Grants Committee and nearly £27 million granted to the Medical Research Council. The remainder was expenditure on research undertaken by the health departments, the Ministry of Defence, the Overseas Development Administration of the Foreign and Commonwealth Office, and the Office of Population Censuses and Surveys.

An important contribution to research in particular subjects is also made by private charities or fund-raising organisations. The Medical Research Council itself receives private benefactions, which, though small in relation to its annual expenditure, provide a useful supplement to its grants from Parliament.

Research carried out by certain industries, primarily the pharmaceutical industry, also makes a major contribution to medicine.

The Medical Research Council

The Medical Research Council has, since 1920, been the main Government agency in Britain for the promotion of all forms of medical research. It also undertakes some medical research overseas. The council is not a Govern-

ment department but an autonomous scientific body, established under Royal Charter, and, besides its advisory functions, it has within certain broad limits full executive control of the public and other funds at its disposal.

Programme Policy

The programme of research work undertaken by the council is planned in accordance with both need and opportunity, and individual items are therefore subject to change. In general, however, the programme includes:

(1) fundamental studies of the structure and natural processes of the body and other organisms which may be associated with it, to provide a basis for the better understanding of problems of health and disease, for example, studies of biochemistry, biophysics, molecular biology, immunology, neurophysiology, and genetics;

(2) clinical and laboratory studies of disease, its nature and causes, and methods for its prevention, diagnosis and treatment, for example, studies in cardiovascular, sensory, mental, alimentary, dental and skin disorders, paediatrics, malignant diseases, tuberculosis, and tropical diseases;

(3) the development and evaluation of special methods of treatment and also of prophylaxis and diagnosis, for example, studies in chemotherapy, radiotherapy, haemotology, pharmacology and of vaccines and other immunological products;

(4) the study of social and occupational factors affecting health and the efficiency of body and mind, for example, studies in social medicine, environmental and occupational physiology, occupational psychology, and occupational diseases; and

(5) the development of methodology and tools for research, for example, in the fields of computer science, epidemiology, and medical statistics.

Currently the council is keeping under continuous review certain socially important health problems including arterial disease, environmental factors in disease, mental health and microbial disease, while it is making special attempts to expand appropriate research on cancer; drug misuse and dependence (especially tobacco and alcohol) and population problems.

Constitution and Finance

The council is responsible to the Secretary of State for Education and Science and consists of a chairman, deputy chairman and not less than 14 nor more than 18 other members. Not less than three-quarters of the members must be appointed on account of their qualifications in science. All members are appointed by the Secretary of State; the scientific members after consultation with the president of the Royal Society and the existing council; and the chairman and deputy chairman after consultation with the existing council. Members all serve four-year terms, retiring in rotation, and scientific members are not eligible for immediate reappointment.

Close relations are maintained by the council with relevant Government departments in Britain, especially the Department of Health and Social Security, the Scottish Home and Health Department, the Welsh Office, the Department of Employment and the Ministry of Overseas Development.

It also collaborates in subjects of common interest with the other research councils (the Agricultural Research Council, the Science Research Council, the Social Science Research Council and the Natural Environment Research Council) and has direct contact with organisations abroad with interests similar to its own.

In the financial year 1973–74 the council's parliamentary grant-in-aid amounted to £25,665,000. In this year there took place the first stage of the arrangements set out in the White Paper *Framework for Government Research and Development* (Cmnd. 5046) for the transfer of funds from the council to the health departments and the Department of Employment to provide resources to these departments to enable them to commission the research needed to achieve departmental policy objectives. The initial amount of funds transferred was about ten per cent of the council's budget. The provision from the grant-in-aid and transferred funds is augmented by further subventions from Government departments and other public bodies and contributions from private sources.

Advisory Boards and Committees

In planning and carrying out its research programme, the council is assisted by four advisory boards; these are the Neurobiology and Mental Health Board, the Cell Biology and Disorders Board, the Physiological Systems and Disorders Board and the Tropical Medicine Research Board. The council is also advised by the Environmental Medicine (Research Policy) Committee on policy for the support of research on environmental, occupational and social medicine problems that often extend beyond the responsibility of its advisory boards. In addition, the council is advised by committees concerned with particular aspects of its work and with research grants.

Support for Medical Research

The Medical Research Council supports and subsidises medical research in four main ways:

(1) It employs a large scientific and technical staff, who work for the most part in the council's own research establishments, which include four large establishments—the National Institute for Medical Research and the National Institute for Biological Standards and Control in London, the Laboratory of Molecular Biology at Cambridge, and the Clinical Research Centre at Northwick Park, Harrow—and over 70 small research units, normally attached to universities and hospitals, throughout the country.[1] On 1 January 1974 there were 1,060 scientific staff, of whom 309 were medically qualified, and 1,645 technical staff.

(2) The council also makes grants for short-term research projects to independent workers, mostly in universities and hospitals. These grants may be made for the personal support of the investigator himself, for the provision of assistance to senior workers, or for research expenses.

[1]See Appendix 3, p. 56.

(3) Long-term support for workers in universities and hospitals is provided by the council's scheme of programme grants. This scheme is intended to support programmes of work consisting of more than one project simultaneously or consecutively and designed to achieve some broad objective. Provided that the work goes well during the initial period of the grant (normally five years) renewal for further periods of up to five years at a time is likely to be considered sympathetically, subject to the competition—and the resources available—at the time when it is requested.

(4) The council awards a number of fellowships and scholarships to enable promising young graduates to be trained under suitable direction in the methods of medical research and particular clinical interests. It also provides awards to enable suitable candidates to receive approved postgraduate instruction in a subject ancillary to their main research interest in the medical or biological sciences. In addition, the council awards travelling fellowships for work at centres overseas; these fellowships are normally tenable for one year.

Clinical Research

The council supports clinical research in several ways. It sets up units and staffs them with its own employees, thus providing opportunities for permanent careers in clinical research; makes appointments to its external scientific staff, either on a whole-time or part-time basis, for work at centres other than its own establishments; makes grants to independent workers not in its own service for the support of specific research project and programmes; and makes provision for the training of research workers. With the assistance of special advisory committees the council also promotes clinical research by organising co-operative studies, including such activities as research in general practice and clinical trials of new remedies likely to lead to fundamental advances in knowledge. In addition, the council is supporting two research establishments in the tropics, which include clinical studies in their programme of work—laboratories at Fajara in The Gambia, and the Epidemiology Unit at Kingston in Jamaica.

In October 1970 the Queen opened a complex, consisting of a hospital and a clinical research centre, at Northwick Park in the London Borough of Brent. The centre provides a clinical counterpart to the National Institute for Medical Research and enables multidisciplinary clinical research to take place in close association with medical services.

The Department of Health and Social Security

The Department of Health and Social Security carries out an extensive programme of research and development related to its responsibilities for health and social care services. Most of the research is carried out externally, but the DHSS also has internal social science, scientific and engineering, and operational research groups. Experimental service developments, extending over all areas of the health and the local authority social services, with associated evaluation of research programmes, are undertaken in collaboration with health and social service authorities. Special financial assistance is

also provided to hospital boards for research which may extend into all parts of the health service.

The external activities include applied research in preventive medicine and in the development of medical practice, which is complementary to research undertaken by the university medical schools and the Medical Research Council; studies related to the determination of social needs and to child care and development; research and development designed to lead to the better assessment and organisation of services, and distribution and management of resources; research in and development of equipment and supplies; and in building and engineering. The estimated cost of these external activities in 1971–72 was £9 million.

The main internal research resource, other than the social science and operational research groups mentioned, is the Biochemical Research and Development Unit at Roehampton, which operates in the field of artificial limbs.

Assistance for hospital research is provided under a scheme devised in agreement with the Medical Research Council. The object of the scheme is to stimulate and encourage doctors in hospital and in practice by providing opportunities for research, of relatively limited financial cost, in matters associated with day-to-day practice. Applicants and health authorities are advised by regional research committees, constituted under the arrangements. There are about 1,200 individual health schemes in health authorities' current programmes. The Department of Health and Social Security will contribute about £1·16 million towards the cost of these, but the total expenditure could amount to more than twice that amount.

Other Government Research

Research is carried out as part of the functions of the Public Health Laboratory Service (see p. 10). Medical research is also conducted by the Ministry of Defence which, among other things, controls the Microbiological Establishment at Porton, Wiltshire, where research has civil as well as military applications. The Transport and Road Research Laboratory, for which the Department of the Environment is responsible, does some research into the physiological problems of driving and accident proneness.

The Agricultural Research Council, the Medical Research Council and the Atomic Energy Authority are all concerned in research into health and safety aspects of nuclear energy.

The Department of Health and Social Security has funds at its disposal for research on aspects of medicine. The Factory Inspectorate of the Department of Employment conducts some studies related to health hazards at work and the Employment Medical Advisory Service conducts research in occupational medicine. The Office of Population Censuses and Surveys also does some research into methodological and other implications of the vital and health statistics which it produces.

Universities and Medical Schools

A large proportion of advanced medical research is undertaken in universities, both in their medical departments and in the various Medical Research Council units attached to them.

There are 18 universities with medical schools in Britain, all of which receive Government grants. Of these, 12 are in England, 1 in Wales, 4 in Scotland and 1 in Northern Ireland. Within London University there are 12 undergraduate medical schools (plus 1 dental only school), the Postgraduate Medical Federation and the London School of Hygiene and Tropical Medicine. The Postgraduate Medical Federation includes the Postgraduate Medical School at Hammersmith and 13 specialist medical institutes.

Trusts and Foundations

Medical research is also promoted and encouraged by a number of charitable trusts and foundations which provide funds and offer fellowships. Among the most important are: The Nuffield Foundation, The Wellcome Trust, The Cancer Research Campaign, The Imperial Cancer Research Fund, The Beit Memorial Fellowships for Medical Research, The National Fund for Research into Crippling Diseases, The Spastics Society, The Mental Health Research Fund, The Arthritis and Rheumatism Council for Research, and The British Heart Foundation.

Industrial Health Research

The Employment Medical Advisory Service; Her Majesty's Factory Inspectorate's Occupational Hygiene Laboratories and the Safety in Mines Research Establishment of the Health and Safety Commission (see p. 32) are engaged in research into industrial health problems. The Employment Medical Advisory Service is concerned with medical research, such as surveys of respiratory disease in pottery and cotton operatives and in workers using asbestos, and the follow-up of people who have been to Industrial Rehabilitation Units. The other parts of the commission tend to concentrate more on the development of means for monitoring and for reducing hazards to health, such as dust, gases and noise. Apart from organisations mentioned under the Medical Research Council section (see p. 42), which may include research with an occupational bearing in their activities, there are a number of employers' organisations concerned with problems specific to their particular industries. There is liaison between these various bodies on matters of common interest.

Health Research by Employers

Research related to health hazards to employees is also conducted by some of the larger employers, notably by the National Coal Board and other public corporations. Product-oriented research related to medicine is conducted in private industrial laboratories in the chemical, pharmaceutical, scientific instrument, medical equipment and electronics industries, while some physiological research on seating, air conditioning and safety factors is carried out by the motor vehicle and aircraft industries.

Great advances have been made in therapeutic drugs during the past few decades in which the British pharmaceutical industry has played a major part. Most of the antibiotics, except penicillin and streptomycin, were discovered by scientists working in the laboratories of pharmaceutical firms, and this is true of most of the sulphonamides, the corticosteroids and the

oral diuretics. (Antibiotics and sulphonamides are used in the treatment of infections caused by bacteria, the corticosteroids for certain skin diseases, allergic diseases and rheumatoid conditions, and the diuretics for hypertension and cardiac oedema.)

Fundamental research carried out by the industry covers the search for new and effective treatment for disease and studies into the nature of disease processes.

PROFESSIONAL QUALIFICATIONS AND TRAINING[1]

PROFESSIONAL standards in the medical and allied professions are maintained in Britain by the practice of registration. Registration carried with it certain privileges for the registered practitioner and constitutes a guarantee of competence to intending patients; in some professions, for example, dentistry, it is pre-requisite for practice. The right and duty of maintaining registers of qualified practitioners is entrusted to the different registering bodies by statutes which govern their composition and procedure, lay down the appropriate training and experience required for admission to the register, and prescribe penalties for people falsely representing themselves to be registered practitioners. The first registering body to be set up was the General Medical Council, established over a century ago by the Medical Act 1858, and it has served as a model for later bodies. The latest councils were established under the Professions Supplementary to Medicine Act 1960. These registering bodies are separate from the professional associations, which exist to protect the interests of persons in medical and associated professions.

Doctors

The current provisions governing the constitution and activities of the General Medical Council are contained in the Medical Act 1956. Under the Act, the General Medical Council consists of 47 members—8 members nominated by the Crown (of whom 3 are laymen), 11 elected members (8 from England and Wales, 2 from Scotland and 1 from Ireland (including the Irish Republic)), and 28 members chosen by the universities and by such bodies as the Royal College of Physicians of London, the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of England, the Royal College of Surgeons of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow.

A change in the composition of the council has been proposed in a working party report and accepted by the council. Implementation of the change will require legislation. In order to become fully registered under the Medical Act, a person must both obtain the qualifications awarded by a university or other body specified in the Act, and also spend a year gaining practical experience under supervision in resident posts in approved hospitals. A doctor has therefore had six to seven years' training in medical school and hospital before he is fully registered. Only fully registered doctors may engage in general practice in the National Health Service.

Apart from the 18 universities in Britain (and two in the Irish Republic[2]) which offer degrees in medicine and surgery, diplomas recognised as qualifications for registration under the Act are granted by such bodies as the Royal Colleges of Physicians and of Surgeons. There is an increasing trend for qualified doctors to take further courses to increase their specialisation and to keep up to date, and provision is made for such doctors receiving grants

[1]For list of professional bodies, see Appendix 4, p. 59.

[2]The registering bodies in the two countries have always recognised each other's qualifications.

to cover course fees and expenses. Examples of higher qualifications obtainable after an original degree or diploma are: university degrees of Doctor of Medicine (MD) and Master of Surgery (MS); Membership or Fellowship of one of the Royal Colleges of Physicians (MRCP, FRCP); Fellowship of one of the Royal Colleges of Surgeons (FRCS) and Membership of the Royal College of General Practitioners (MRCGP). Diplomas are awarded by the appropriate examining bodies for aptitude in special subjects, for example, the Diploma in Public Health (DPH) and the Diploma in Psychological Medicine (DPM).

Each of the 12 undergraduate medical schools of London University is linked with one of the teaching hospitals—St Bartholomew's ('Barts'), St Thomas', St Mary's, St George's, the London, the Middlesex, Westminster, the Royal Free, University College, King's College, Guy's or Charing Cross. These hospitals are used for postgraduate as well as undergraduate training, but other London teaching hospitals are reserved for postgraduate study. There are also medical schools associated with teaching hospitals at Birmingham, Bristol, Cambridge, Leeds, Liverpool, Manchester, Newcastle, Nottingham, Oxford, Sheffield and Southampton, while facilities for postgraduate medical training are being developed in many other hospitals, and this tendency is likely to increase.

The teaching hospitals in Wales are in Cardiff and linked with the University of Wales. In Scotland there are five medical schools, at the Universities of Aberdeen, Dundee, Edinburgh, and Glasgow, and in Northern Ireland one, at Queen's University, Belfast. Postgraduate training is also available at these centres.

Changes in undergraduate courses for medical students, in professional training for postgraduate students, mergers of certain London medical schools and the expansion of facilities for medical education are taking place on the basis of recommendations contained in the report of the Royal Commission on Medical Education, published in April 1968 (Cmnd 3569).

Doctors have several professional associations, the largest of which is the British Medical Association.

Dentists

Under the Dentists Act 1957, the dental profession is governed by the General Dental Council, which consists of 38 members: 3 dentists and 3 laymen nominated by the Crown, 1 layman nominated by the Governor of Northern Ireland, 20 dentists nominated by the authorities granting degrees or diplomas and 11 elected by their fellow dentists (7 for England, 1 for Wales, 2 for Scotland and 1 for Northern Ireland). In addition, 6 members of the General Medical Council act and vote as members of the General Dental Council, but only in connection with dental education and examinations.

Thirteen universities in Britain and two in the Irish Republic grant degrees in dental surgery (BDS) or diplomas as Licentiate of Dental Surgery (LDS). Also, diplomas are granted by the Royal College of Surgeons of England, the Royal College of Surgeons in Ireland, the Royal College of Surgeons of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow.

Since 1962 the number of places in the dental schools in Great Britain has been increased by 50 per cent—from about 600 to 900 currently.

Higher qualifications obtainable after initial qualifications are: Master of Dental Surgery (MDS); Doctor of Dental Surgery (DDS); Fellowship in Dental Surgery (FDS); and Fellowship of the Faculty of Dentistry (FFD). Additional qualifications are: Diploma in Orthodontics (D.Orth); Diploma in Dental Orthopaedics (DDO); Diploma in Public Dentistry (DPD); and Diploma in Dental Public Health (DDPH).

Some simple work under supervision may be performed by dental auxiliaries who have undergone a two-year training course.

The dentists' principal professional association is the British Dental Association.

Other Professions

Nurses and Midwives

Until 1974, training for the Register of Nurses has normally taken three years and might be for the general, mental or sick children's parts of the Register.

It was usual, however, to combine training as a Sick Children's Nurse with general training in a period of three years and six to eight months.

On qualifying, the registered nurse has been entitled to use the letters SRN—State Registered Nurse (in Scotland, RGN—Registered General Nurse), RMN—Registered Mental Nurse, or RNMS—Registered Nurse for the Mentally Subnormal, RSCN—Registered Sick Children's Nurse, as appropriate, after his or her name.

Training has taken place mainly in hospital with visits to, or some experience in, community health services. Theoretical teaching has usually been arranged by withdrawing students for study blocks at intervals during training and by clinical teaching during practical experience.

Courses combining nurse education and training with a university degree have been available in several centres in subjects such as sociology, social science, human biology, economics and life sciences. More recently degrees in nursing have been established. Shortened courses (112 weeks) for university graduates to qualify as registered nurses have become available in several teaching hospitals. Other courses for candidates of above-average ability have also been developed. These might combine general nurse training with a higher nursing qualification (Diploma in Nursing) or with health visitor training and/or preparation for district nursing or the inclusion of specialist clinical experience during the third year.

Women or men who have taken a shorter two-year course of training with more emphasis on practical work have been able to qualify as enrolled nurses and are entitled to use the letters SEN (State Enrolled Nurse). They might work in any type of hospital (depending on the field of nursing in which they have trained), or in the community (after further training) under the supervision of a registered nurse.

A Committee on Nursing under the chairmanship of Professor Asa Briggs reported in October 1972 and made major recommendations which have in large part been accepted by the Government, including a streamlining of nursing training, so that all nurses would start by taking the same basic course.

The educational bodies for nursing and midwifery are The General Nursing

Councils for England and Wales, Scotland, Joint Nursing and Midwives Council Northern Ireland, which keep the Registers and Rolls; and the Central Midwives Board.

Pharmacists

Pharmacy is regulated by the Pharmacy Act 1954 and by-laws made under the Act. Only registered pharmaceutical chemists may describe themselves, or practise, as pharmacists, and qualifications requiring four years' academic study and practical training are necessary for registration. The governing body of the profession, responsible for keeping the Register, is the Pharmaceutical Society of Great Britain.

Opticians

There are two types of optician—the ophthalmic optician, who usually both tests sight and supplies glasses, and the dispensing optician, who only supplies glasses. Training as a dispensing optician is mainly part-time, although almost all students take at least a short period of full-time study. Training as an ophthalmic optician consists mainly of three years' full-time study, followed by a year under supervision. The profession is regulated by the General Optical Council, set up under the Opticians Act 1958, and only registered ophthalmic opticians (or registered medical practitioners) are allowed to test sight.

Professions Supplementary to Medicine

State registers have been established for chiropodists, dietitians, medical laboratory technicians, occupational therapists, orthoptists, physiotherapists, radiographers and remedial gymnasts under the Professions Supplementary to Medicine Act 1960. The registering bodies are eight boards (for example, The Chiropodists' Board or The Dietitians' Board), under the general supervision of the Council for Professions Supplementary to Medicine. A professional training, which varies from 2 to 3 years according to the profession is needed to qualify for registration. Only state registered members of these professions may be employed in the National Health Service and some other public services.

Social Workers

Training for most types of social work consists of a basic university degree, diploma or certificate course in social science followed by a university course in applied social studies or specialised training for a particular service. Training is also possible in colleges of further education. Recognised courses for field and residential social workers are provided by universities, polytechnics and colleges of further education and vary in length and pattern according to previous educational qualifications. The statutory body responsible for recognition of these courses in Britain is the Central Council for Education and Training in Social Work. Information and advice on social work training is obtainable from the Social Work Advisory Service.

Health Visitors

Health visitors are State Registered Nurses with a midwifery qualification or who have taken an approved course of obstetric nursing before taking

a year's course in health visiting leading to a certificate in health visiting. The Council for the Training of Health Visitors set up under the Health Visiting and Social Work (Training) Act 1962 is responsible for the training of health visitors.

Public Health Inspectors

Public health inspectors appointed by local authorities in England and Wales are required to possess the diploma of the Public Health Inspectors Education Board. The board regulates training, which usually covers a period of four years and includes practical training in the public health inspector's department of a local authority and theoretical instruction at a technical college. University courses for B.Sc. in environmental health also qualify for the diploma.

In Scotland the recognised qualification is the certificate of the Royal Sanitary Association of Scotland.

Speech Therapists

Speech therapists need a good general education and three years' professional training. The usual qualification is that of the College of Speech Therapists but there is also a degree course at Newcastle University, leading to the qualification of Bachelor of Education (Speech).

Overseas Qualifications

A large number of doctors, dentists, nurses and other medical and auxiliary workers with overseas qualifications are at work in Britain. The regulations and criteria governing recognition of overseas qualifications and the right to practise in Britain are separate, complex and different for each registering body and are in many cases in process of review and change, both because of Britain's entry into the European Community and for a number of other reasons. Assessment of the standard of the overseas training received is, of course, vital in deciding whether to accord full qualification in Britain. But there may be other factors, for example, the existence of reciprocal arrangements or the passing of a special examination, set for this purpose by the registering body. And there may be arrangements for temporary or provisional qualification.

APPENDIX 1

PRIVATE MEDICINE

Nearly all residents in Britain use the National Health Service (NHS). The majority of the population are registered as NHS patients of a family doctor and only a very small number have a family doctor whom they consult privately on a fee-paying basis.

However, an NHS family doctor may refer a patient for private consultation or private treatment as an in-patient and a number of people do in certain circumstances prefer to pay for private consultations and treatment. This private treatment, which is largely provided by consultants whose main work is in the NHS, may take place in NHS hospitals authorised for the treatment of private patients, or in private consulting rooms or hospitals and institutions outside the NHS. Private consultations may also be followed by treatment under the NHS.

The evidence with regard to the extent of the use of private medical services is incomplete and not wholly consistent, but among the major users are the families of subscribers to the provident schemes, which make limited payments for private health care in return for annual subscriptions. There are about a million subscribers to such schemes, which cover 2·1 million people. Many of the middle-grade or senior staff of firms are covered by group schemes for such employees.

The total subscription income of provident schemes in 1973 was about £29 million, and total benefits paid about £24 million—that is, less than 1 per cent of total NHS expenditure and less than 2 per cent of NHS expenditure on hospital and specialist services, on which the benefits are mainly concentrated.

About half the payments are for consultants' and specialists' fees and most of the rest pay for beds in hospitals in the NHS or outside it.

The total national expenditure on private health care (apart from medicines) may be very roughly estimated at between £45 million and £55 million on the basis of figures in the sample Family Expenditure Survey and the known NHS figures. This suggests that apart from the provident schemes, an approximately equivalent amount is spent directly by individuals. In addition, insurance companies pay for a large number of medical examinations in connection with life insurance and accident compensation.

The total in-patient accommodation for private patients is about 7 per cent of that for NHS patients. In England and Wales there are about 4,500 pay beds (that is, about 1 per cent of all beds in NHS hospitals). They are occupied 55 per cent of the time by private patients but may at other times be used by NHS patients. The length of stay of private patients averages about eight days. There are nearly 27,000 beds in some 1,130 private nursing homes registered with local authorities, of which some 5,000 beds in over 80 homes are for the mentally ill and many of the remainder are in small homes for the aged. There are, however, some large well-equipped nursing homes and a few privately endowed hospitals.

Apart from people from overseas who come to this country for medical treatment because of the high prestige of British medicine and who are ineligible for treatment under the NHS, the main motives for people seeking private treatment appear to be the wish for greater freedom in arranging consultations and hospital admission at times convenient to themselves, the desire for privacy and the wish to be treated by a consultant of their choice. (There is no evidence that private treatment is often sought in the belief that the standard of medical care will be higher than that under the NHS.)

APPENDIX 2

PUBLIC EXPENDITURE ON THE HEALTH AND PERSONAL SOCIAL SERVICES IN BRITAIN*

£ *million*

	1951–52	1961–62	1972–73	1973–74
Current expenditure				
Hospital, etc., services†	275	551	1,885	1,883
less Receipts from patients	−3	−6	−16	−18
General medical, etc., services†	166	274	678	735
less Receipts from patients	−4	−41	−74	−80
of which (net cost):				
Pharmaceutical services	53	77	257	283
General dental services	36	52	102	111
General ophthalmic services	10	10	15	16
General medical services	59	88	212	229
Local authority services:				
Health	38	82	173	198
Personal social services‡	29	56	372	448
School meals and milk:				
School milk§	10	14	9	9
School meals	42	85	257	325
less Payments by parents	−16	−35	−102	−111
Welfare foods†	32	29	13	12
Departmental administration, other services, etc.	7	19	73	100
Total current expenditure	576	1,028	3,048	3,501
Capital expenditure				
Hospital, etc., services	15	44	231	256
Local authority health and personal social services	7	15	73	105
Other services	6	3	56	16
Total capital expenditure	28	62	310	377
Total public expenditure on health and personal social services	604	1,090	3,358	3,878
Capital and current expenditure (net) expressed as percentage of total expenditure on health and personal social services:				
Hospital, etc., services	47·5	54·0	56·0	54·7
Pharmaceutical services	8·8	7·1	7·7	7·3
General dental services	6·0	4·8	3·0	2·9
General ophthalmic services	1·7	0·9	0·4	0·4
General medical services	9·8	8·1	6·3	5·9
Local authority health services	6·8	8·1	5·7	5·8
Local authority personal social services‡	5·5	6·0	12·7	13·6

Source: Central Statistical Office.

*Including current expenditure on school meals and milk.
†Including administration.
‡Including, from 1969–70 some services transferred from local authority health services.
§ Expenditure on school milk was borne by the central Government in 1951–52.

APPENDIX 3

MEDICAL RESEARCH COUNCIL ESTABLISHMENTS

National Institute for Medical Research, Mill Hill, London NW7 1AA.

Clinical Research Centre, Watford Road, Harrow, Middlesex, HA1 3UJ.

National Institute for Biological Standards and Control, Holly Hill, London NW3 6RB.

MRC Abnormal Haemoglobin Unit, University Department of Biochemistry, Addenbrookes Hospital, Cambridge CB2 2QR.

MRC Air Pollution Unit, St Bartholomew's Hospital Medical College, Charterhouse Square, London EC1M 6BQ.

MRC Applied Psychology Unit, 15 Chaucer Road, Cambridge CB2 2EF.

MRC Biochemical Parasitology Unit, Molteno Institute, Downing Street, Cambridge CB2 3EE.

MRC Blood Group Reference Laboratory (administered by the Council for the Department of Health and Social Security), Gatliff Road, off Ebury Bridge Road, London SW1W 8QJ.

MRC Blood Group Unit, Lister Institute of Preventive Medicine, Chelsea Bridge Road, London SW1W 8RH.

MRC Blood Pressure Unit, Western Infirmary, Glasgow G11 6NT.

MRC Brain Metabolism Unit, Department of Pharmacology, University of Edinburgh, 1 George Square, Edinburgh EH8 9JZ.

MRC Cell Biophysics Unit, University of London, Department of Biophysics, Kings College, 26–29 Drury Lane, London WC2B 5RL.

MRC Cell Mutation Unit, University of Sussex, Falmer, Brighton BN1 9QH.

MRC Cellular Immunology Unit, Sir William Dunn School of Pathology, Oxford OX1 3RE.

MRC Clinical and Population Cytogenetics Unit, Western General Hospital, Crewe Road, Edinburgh EH4 2XU.

MRC Clinical Genetics Unit, Institute of Child Health, 30 Guilford Street, London WC1N 1EH.

MRC Clinical Pharmacology Unit, Radcliffe Infirmary, Woodstock Road, Oxford OX2 68E.

MRC Clinical Psychiatry Unit, Graylingwell Hospital, Chichester, West Sussex.

MRC Department of Clinical Research, University College Hospital Medical School, University Street, London WC1E 6JJ.

MRC Computer Unit (London), 242 Pentonville Road, London N1 9LB.

MRC Cyclotron Unit, Hammersmith Hospital, Du Cane Road, London W12 0HS.

MRC Demyelinating Diseases Unit, Newcastle General Hospital, Westgate Road, Newcastle upon Tyne NE4 6BE.

MRC Dental Unit, Dental School, Lower Maudlin Street, Bristol BS1 2LY.

MRC Dental Epidemiology Unit, The London Hospital Medical College, Turner Street, London E1 2AD.

MRC Unit on the Development and Integration of Behaviour, Subdepartment of Animal Behaviour, Madingley, Cambridge CB3 8AA.

MRC Development Psychology Unit, Drayton House, Gordon Street, London WC1H 0AN.

Dunn Nutrition Unit, Milton Road, Cambridge CB4 1XJ.

MRC Unit for the Study of Environmental Factors in Mental and Physical Illness, London School of Economics and Political Science, 20 Hanway Place, London W1P 0AJ.

MRC Environmental Physiology Unit, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT.

MRC Epidemiology Unit (Jamaica), University of the West Indies, Mona, Kingston 7, Jamaica.

MRC Epidemiology Unit (South Wales), 4 Richmond Road, Cardiff CF2 3AS.

MRC-DHSS Epidemiology and Medical Care Unit (jointly with the Department of Health and Social Security), Northwick Park Hospital, Watford Road, Harrow HA1 3UJ.

MRC Unit for Epidemiological Studies in Psychiatry, University Department of Psychiatry, Royal Edinburgh Hospital, Morningside Park, Edinburgh EH10 5HF.

MRC Experimental Haematology Unit, St Mary's Hospital Medical School, London W2 1PG.

MRC Unit on the Experimental Pathology of Skin, The Medical School, Birmingham University, Birmingham B15 2TJ.

MRC Gastroenterology Unit, Central Middlesex Hospital, Park Royal, London NW10 7NS.

MRC Hearing and Balance Unit, Institute of Neurology, National Hospital, Queen Square, London WC1N 3BG.

MRC Human Biochemical Genetics Unit, The Galton Laboratory, University College London, Wolfson House, 4 Stephenson Way, London NW1 2HE.

MRC Immunochemistry Unit, University Department of Biochemistry, South Parks Road, Oxford OX1 3QU.

MRC Industrial Injuries and Burns Unit, Birmingham Accident Hospital, Bath Row, Birmingham B15 1NA.

MRC Laboratories, The Gambia, Fajara, PO Box 273 Banjul, The Gambia, West Africa.

MRC Laboratory Animals Centre, Medical Research Council Laboratories, Woodmansterne Road, Carshalton, Surrey SM5 4EF.

MRC Unit for Laboratory Studies of Tuberculosis, Royal Postgraduate Medical School, Du Cane Road, London W12 0HS.

MRC Leukaemia Unit, Royal Postgraduate Medical School, Du Cane Road, London W12 0HS.

MRC Lipid Metabolism Unit, Hammersmith Hospital, Du Cane Road, London W12 0HS.

MRC Mammalian Development Unit, Wolfson House, University College London, 4 Stephenson Way, London NW1 2HE.

MRC Mammalian Genome Unit, University Department of Zoology, West Mains Road, Edinburgh EH9 3JT.

MRC Medical Sociology Unit, Centre for Social Studies, Westburn Road, Aberdeen AB9 2ZE.

MRC Unit for Metabolic Studies in Psychiatry, University Department of Psychiatry, Middlewood Hospital, PO Box 134, Sheffield S6 1TP.

MRC Microbial Systematics Unit, Adrian Building, University Road, Leicester LE1 7RH.

MRC Mineral Metabolism Unit, The General Infirmary, Great George Street, Leeds LS1 3EX.

MRC Laboratory of Molecular Biology, University Postgraduate Medical School, Hills Road, Cambridge CB2 2QH.

MRC Unit on Neural Mechanisms of Behaviour, Department of Psychology, University College London, 3 Malet Place, London WC1E 7JG.

MRC Neurochemical Pharmacology Unit, University Department of Pharmacology Hills Road, Cambridge CB2 2QD.

MRC Neurological Prostheses Unit, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF.

MRC Neuropharmacology Unit, The Medical School, Birmingham B15 2TJ.

MRC Neuropsychiatry Unit, Medical Research Council Laboratories, Woodmansterne Road, Carshalton, Surrey SM5 4EF.

MRC Unit for Physical Aids for the Disabled, Princess Margaret Rose Orthopaedic Hospital, Fairmilehead, Edinburgh EH10 7ED.

MRC Pneumoconiosis Unit, Llandough Hospital, Penarth, Glamorgan CF6 1XW.

MRC Population Genetics Unit, Old Road, Headington, Oxford OX3 7LE.

MRC Radiobiology Unit, Harwell, nr Didcot, Berkshire.

MRC Reproduction and Growth Unit, Princess Mary Maternity Hospital, Great North Road, Newcastle upon Tyne NE2 3BD.

MRC Unit on Reproductive Biology, Department of Obstetrics and Gynaecology, University of Edinburgh, 39 Chalmers Street, Edinburgh EH3 9ER.

MRC Rheumatism Unit, Carnation Red Cross Memorial Hospital, Taplow, Maidenhead, Berkshire.

MRC Social and Applied Psychology Unit, Department of Psychology, University of Sheffield, Sheffield S10 2TN.

MRC Social Medicine Unit, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT.

MRC Social Psychiatry Unit, Institute of Psychiatry, De Crespigny Park, London SE5 8AF.

MRC Statistical Research and Services Unit, University College Hospital Medical School, 115 Gower Street, London WC1E 6AS.

MRC Toxicology Unit, Medical Research Council Laboratories, Woodmansterne Road, Carshalton, Surrey SM5 4EF.

MRC Tuberculosis and Chest Diseases Unit, Brompton Hospital, Fulham Road, London SW3 6HP.

MRC Virology Unit, Institute of Virology, Church Street, Glasgow G11 5JR.

MRC Vision Unit, School of Biological Sciences, University of Sussex, Falmer, Brighton BN1 9QY.

APPENDIX 4

HEALTH DEPARTMENTS AND ORGANISATIONS

GOVERNMENT DEPARTMENTS AND OFFICIAL BODIES

Department of Health and Social Security, Alexander Fleming House, London SE1 6BY.

Department of the Environment, 2 Marsham Street, London SW1 3EB.

Department of Trade and Industry, 1 Victoria Street, London SW1H 0ET.

Department of Employment, 8 St James's Square, London SW1Y 4JB.

Department of Education and Science, Elizabeth House, York Road, London SE1.

Ministry of Agriculture, Fisheries and Food, 3 Whitehall Place, London SW1A 2HH.

Admin, Great Westminster House, HG GE, Horseferry Road, London SW1.

Welsh Office, Cathays Park, Cardiff.

Office of Population Censuses and Surveys, Somerset House, London WC2R 1LR.

Scottish Education Department, St Andrew's House, Edinburgh EH1 3DB.

Scottish Home and Health Department, St Andrew's House, Edinburgh EH1 3DE.

Ministry of Health and Social Services, Dundonald House, Upper Newtownards Road, Belfast BT4 3SF.

Ministry of Education (Northern Ireland), Rathgael House, Balloo Road, Bangor, County Down.

Public Health Laboratory Service Board, 24 Park Crescent, London W1N 4DA.

Central Midwives Board, 39 Harrington Gardens, London SW7 4JY.

Central Midwives Board for Scotland, 24 Dublin Street, Edinburgh EH1 3PU.

Council for Professions Supplementary to Medicine, York House, Westminster Bridge Road, London SE1 7UH.

Council for the Training of Health Visitors, Clifton House, Euston Road, London NW1 2RR.

Central Council for Education and Training in Social Work, Clifton House, Euston Road, London NW1 2RS.

General Dental Council, 37 Wimpole Street, London W1M 8DQ.

General Medical Council, 44 Hallam Street, London W1N 6AE.

General Nursing Council for England and Wales, 23 Portland Place, London W1A 1BA.

General Nursing Council for Scotland, 5 Darnaway Street, Edinburgh EH3 6DP.

General Optical Council, 41 Harley Street, London W1N 2DJ.

Medical Research Council, 20 Park Crescent, London W1N 4AL.

Mental Welfare Commission for Scotland, 22 Melville Street, Edinburgh EH3 7NS.

PROFESSIONAL BODIES

Apothecaries, The Society of, Apothecaries Hall, Blackfriars Lane, London EC4V 6EJ.

Association of Dispensing Opticians, 22 Nottingham Place, London W1M 4AT.

Association of Industrial Medical Officers, RCS, Lincoln's Inn Fields, London WC2A 3PN.

Association of Mental Health Workers, 39 Queen Anne Street, London W1M 9FA.

Association of Occupational Therapists, 251 Brompton Road, London SW2 2HA.

Association of Optical Practitioners, 27 Three Kings Yard, London W1.

Association of Public Health Inspectors, 19 Grosvenor Place, London SW1X 7HU.

British Dental Association, 63 Wimpole Street, London W1M 8AL.

British Association of Physical Medicine and Rheumatology, c/o Royal College of Physicians, 11 St Andrew's Place, London NW1 4LE.

British Association of Social Workers, 16 Kent Street, Birmingham B5 6RD.

British Dietetic Association (Inc), 251 Brompton Road, London SW3 2ES.

British Medical Association, BMA House, Tavistock Square, London WC1H 9JP.

The British Optical Association, 65 Brook Street, London W1Y 2DT.

British Orthopaedic Association, RCS, Lincoln's Inn Fields, London WC2A 3PN.

British Orthoptic Board and Society, Tavistock House, Tavistock Square, London WC1H 9JB.

British Paediatric Association, c/o Institute of Child Health, 30 Guilford Street, London WC1N 1EH.

British Psycho-Analytical Society, 64 New Cavendish Street, London W1M 7RD.

British Tuberculosis Association, 59 Portland Place, London W1N 3DG.

Chartered Society of Physiotherapy, 14 Bedford Row, London WC1R 4ED.

College of Pathologists, 16 Park Crescent, London W1N 3PA.

College of Speech Therapists, 247 St John's Wood High Street, London NW8 7NJ.

Federation of Association of Mental Health Workers, 39 Queen Anne Street, London W1M 9LB.

Health Visitors' Association, 36 Eccleston Square, London SW1V 1PF.

Institute of Health Service Administrators, 75 Portland Place, London W1N 4AN.

Institute of Medical Laboratory Technology, 12 Queen Anne Street, London W1M 0AU.

Institute of Personnel Management, 5 Winsley Street, Oxford Circus, London W1N 7AQ.

Institute of Welfare Officers (Industrial), 56 Stamford Street, London SE1 9LX.

National Association of Teachers of the Mentally Handicapped, 12 Saxenhurst Road, Bournemouth, Dorset, BH10 6JH.

Pharmaceutical Society of Great Britain, 17 Bloomsbury Square, London WC1A 2NN.

Queen's Institute of District Nursing, 57 Lower Belgrave Street, London SW1 0LR.

Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.

Royal College of Midwives, 15 Mansfield Street, London W1M 0BE.

Royal College of Nursing and National Council of Nurses of the United Kingdom, 1A Henrietta Place, London W1M 0AB.

Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, London NW1 4RG.

Royal College of Physicians, St Andrew's Place, London NW1 4LE.

Royal College of Physicians, 9 Queen Street, Edinburgh EH2 1JQ.

Royal College of Physicians and Surgeons, 242 St Vincent Street, Glasgow G2 5RJ.

Royal College of Surgeons of Edinburgh, Nicolson Street, Edinburgh EH8 9DW.

Royal College of Surgeons of England, Lincoln's Inn Fields, London WC2A 3PN.

Royal Institute of Public Health and Hygiene, 28 Portland Place, London W1N 4DE.

Royal Medico-psychological Association, Chandos House, 2 Queen Anne Street, London W1M 9LE.

Royal Society of Health, 90 Buckingham Palace Road, London SW1W 0SX.

The Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE.

Society of Chiropodists, 8 Wimpole Street, London W1M 8BX.

Society of Medical Officers of Health, Tavistock House South, Tavistock Square, London WC1H 9LD.

Society of Radiographers, 14 Upper Wimpole Street, London W1M 8BN.

OTHER BODIES

Arthritis and Rheumatism Council, The, 8 Charing Cross Road, London WC2H 0HN.

British Cancer Council, 19a St Michael's Road, London SW9.

British Council for the Rehabilitation of the Disabled, Tavistock House South, Tavistock Square, London WC1H 9LB.

British Diabetic Association, 3 Alfred Place, London WC1E 7EE.

British Epilepsy Association, 3 Alfred Place, London WC1E 7ED.

British Heart Foundation, 57 Gloucester Place, London W1H 4DH.

British Polio Fellowship, Clifton House, Euston Road, London NW1 2RJ.

British Red Cross Society, 9 Grosvenor Crescent, London SW1X 7EQ.

British Rheumatism and Arthritis Association, 1 Devonshire Place, London W1N 2ED.

British United Provident Association, Provident House, 24 Essex Street, London WC2R 3AX.

Cancer Research Campaign, 2 Carlton House Terrace, London SW1Y 5AF.

Central Council for the Disabled, 34 Eccleston Square, London SW1V 1PE.

Central Council for Physical Recreation, London & S.E. Region & Regional Sports Council, 160 Great Portland Street, London W1.

Chest and Heart Association, Tavistock House North, Tavistock Square, London WC1H 9JE.

Children's Research Fund, 6 Castle Street, Liverpool L2 0NA.

Family Planning Association, Margaret Pyke House, 27–35 Mortimer Street, London W1A 4QW.

Health Education Council, 7–12 Lynton House, Tavistock Square, London WC1H 9LT.

Imperial Cancer Research Fund, 44 Lincoln's Inn Fields, London WC2A 3PX.

Industrial Society, 48 Bryanston Square, London W1H 8AH.

Institute of Cancer Research, 34 Summer Place, London SW7 3NU.

Invalid Children's Aid Association, 126 Buckingham Palace Road, London SW1W 9SB.

King Edward's Hospital Fund for London, 14 Palace Court, London W2 4HT.

Leukaemia Research Fund, 61 Great Ormond Street, London WC1N 3HZ.

Marie Curie Memorial Foundation, 124 Sloane Street, London SW1X 9BP.

Mental After Care Association, 110 Jermyn Street, London SW1Y 6HB.

Multiple Sclerosis Society, 4 Tachbrook Street, London SW1V 1SH.

Muscular Dystrophy Group, 26 Borough High Street, London SE1 9QG.

National Association for Maternity and Child Welfare, BMA House, Tavistock Square, London WC1H 9JG.

National Association for Mental Health, 39 Queen Anne Street, London W1M 0AJ.

National Association of Leagues of Hospital Friends, 44 Fulham Road, London SW3.

National Council for the Unmarried Mother and Her Child Inc., 255 Kentish Town Road, London NW5 2LX.

National Institute of Industrial Psychology, 14 Welbeck Street, London W1M 8DR.

National Society for Autistic Children, 1A Golders Green Road, London NW11 8EA.

National Society for Cancer Relief, 30 Dorset Square, London NW1 6QL.

National Society for Clean Air, 134 North Street, Brighton BN1 1RG.

National Society for Epileptics, Chalfont Colony, Chalfont St Peter, Bucks.

National Society for Mentally Handicapped Children, 86 Newman Street, London W1P 4AR.

National Society of Children's Nurseries, Montgomery Hall, Kennington Oval, London SE11.

Nuffield Provincial Hospitals Trust, 3 Prince Albert Road, London NW1 7SP.

Royal National Institute for the Blind, 224 Great Portland Street, London W1N 6AA.

Royal National Institute for the Deaf, 105 Gower Street, London WC1E 6AH.

Royal Society for the Prevention of Accidents, Terminal House, 52 Grosvenor Gardens, London SW1W 0AX.

St Andrew's Ambulance Association, Milton Street, Glasgow G4 0HR.

St Dunstan's (for Services war-blinded), 191 Marylebone Road, London NW1 5QN.

St John Ambulance Association, 1 Grosvenor Crescent, London SW1X 7EF.

Scottish Accident Prevention Council, 13 Abercromby Place, Edinburgh EH3 6LB.

Scottish Association for Mental Health, 57 Melvill Street, Edinburgh EH3 7HL.

Scottish Association for the Deaf, 158 West Regent Street, Glasgow G2 4RJ.

Scottish Council for Health Education, 21 Lansdowne Crescent, Edinburgh 12.

Scottish Council for the Care of Spastics, Rhuemore, Corstorphine Road, Edinburgh EH12 6HP.

Scottish Council for the Unmarried Mother and Her Child, 44 Albany Street, Edinburgh EH1 3QR.

Scottish Council of Physical Recreation, 4 Queensferry Street, Edinburgh EH2 4PB.

Scottish Epilepsy Association, 24 St Vincent Place, Glasgow G1 2EU.

APPENDIX 5

PRINCIPAL STATUTES

(Obtainable from HMSO, London, and its agents unless otherwise stated.)

PUBLIC HEALTH

Alkali, Etc., Works Regulation Act 1966. 13½p

Public Health Act 1936. £1·35

Burgh Police (Scotland) Act 1892. 75p

Public Health (Scotland) Act 1897. 47½p

Water Resources Act 1963. 95p

Water Resources Act 1968. 2½p

Clean Air Act 1956. 22½p

Clean Air Act 1968. *SBN 10 546268 3.* 10p

Housing Act 1967. 80p

Housing Act 1961. 21p

Housing Act 1964. 42½p

Food and Drugs Act 1955. 68p

Dangerous Drugs Act 1965. 13½p

Dangerous Drugs Act 1967, 9p

Health Services and Public Health Act 1968. *SBN 10 544668 8.* 35p

Medicines Act 1968. *SBN 10 546578 5.* 95p

Medicines Act 1971. *SBN 10 546971 8.* 3p

Misuse of Drugs Act 1971. *SBN 10 543871 6.* 30p

Public Health Act 1971. *SBN 10 545872 4.* 47p

Water Act 1973

NATIONAL HEALTH SERVICE

Health Services Act (Northern Ireland) 1948. *HMSO, Belfast*

Mental Health Act 1959. 12½p

National Health Service Act 1946. 63p

National Health Service Act 1952. 8p

National Health Service Contributions Act 1957. 4p

National Health Service (Amendment) Act 1957. 2½p

National Health Service Contributions Act 1961. 2½p

National Health Service Act 1961. 2p

National Health Service (Hospital Boards) Act 1964. 1p

National Health Service Act 1966. 6p

National Health Service Contributions Act 1970. 2½p

National Health Service (Scotland) Act 1972. *SBN 10 545872 4.* 47p

National Health Service (Reorganisation) Act 1973

OCCUPATIONAL HEALTH

Children and Young Persons Acts 1933–63. (Various prices)

Employment Medical Advisory Service Act 1972. *SBN 10 542872 8.* 13p

Factories Act 1961. 60p

Factories Act (Northern Ireland) 1965. *HMSO, Belfast*

Health and Safety at Work Act 1974

Mines and Quarries Act 1954. 80p

Agriculture (Safety, Health and Welfare Provisions) Act 1956. 13½p

Offices, Shops and Railway Premises Act 1963. 32½p

Radioactive Substances Act 1960

MEDICAL AND ALLIED PROFESSIONS

Professions Supplementary to Medicine Act 1960. 7½p

Health Visiting and Social Work Training Act 1962. 5p

APPENDIX 6

HEALTH SERVICE STATISTICS (GREAT BRITAIN)

1. HOSPITAL SUMMARY

	1954	1961	1971	1972
In-patients:				
Discharges and deaths (thousands)	4,119	4,852	6,207	6,278
of which private in-patients ..	72*	84*	115*	120*
Average number of beds occupied daily (thousands)	483	457	421	415
of which private in-patients ..	3	3	3	3
Average length of stay (days):				
All patients	42·8	34·5	24·7	24·2
Excluding psychiatric, geriatric and chronic sick patients ..	—	14·5	10·4	10·2
Waiting lists (thousands)	—	—	578	563
of which surgical patients ..	—	—	539	527
Out-patients (excluding accident and emergency):				
New patients (thousands) ..	—	10,219	10,580	10,435
Average attendances per new patient	—	3·5	4·0	4·1
Accident and emergency patients:				
New patients (thousands) ..	—	5,402	9,054	9,283
Average attendances per new patient	—	2·5	1·7	1·6
Rates per 1,000 population:				
In-patients:				
Discharges and deaths ..	83·4	94·2	114·9	115·7
Waiting lists	—	—	10·7	10·3
Out-patients (excluding accident and emergency):				
New patients	—	199	196	192
Accident and emergency patients:				
New patients	—	105	168	171

*England and Wales only.

2. NATIONAL HEALTH SERVICE MANPOWER SUMMARY
(Great Britain)

	1965	1969	1972
Hospital Services			
Medical staff*	22,123	25,674	29,360
Hospital dental staff*	663	840	938
Hospital nursing staff	264,683	300,598	350,330
Hospital midwifery staff	17,333	19,438	20,680
Hospital professional and technical staff*	31,659	37,930	44,328
Hospital ancillary staff	241,037	257,351	274,189
Hospital administrative and clerical staff*	41,767	48,392	57,140
Regional hospital boards headquarters staff	5,755	7,314	9,736
Mass radiography units and blood transfusion units staff	3,414	3,762	4,042
General Practitioner Services			
General medical practitioners	24,260	24,239	25,184
General dental practitioners	11,572	11,761	12,332
Ophthalmic medical practitioners ..	887	950	988
Opticians	7,317	6,729	6,639
Executive councils' staff*	4,467	5,266	5,609
Dental estimates board*	1,435	1,387	1,450
Joint pricing committees, drug accounts and pay accounts committee staff* ..	2,102	2,266	2,146
Local Authority Services			
Nursing staff*	23,854	25,201	28,685

*Whole-time equivalent.

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READING LIST

General Publications

			£
Brockington, C. F. A Short History of Public Health. Second edition. *ISBN 0 7000 1031 9.*	*John Churchill*	1966	1·75
Ferrer, H. P. (*editor*). The Health Services—Administration, Research and Management. *ISBN 0 407 19920 9.*	*Butterworths*	1972	7·80
Jones, K. A History of the Mental Health Services. *ISBN 0 7100 7452 2.*	*Routledge*	1972	5·00
Lee, M. Opting Out of the National Health Service. PEP Broadsheet 527. *ISBN 0 85374 038 0.*	*Political and Economic Planning*	1971	0·50
Mencher, S. Private Practice in Britain. *ISBN 0 7135 0747 0.*	*Bell*	1968	0·75
Nuffield Provincial Hospitals Trust. Mounting the health guard.	*The Trust*	1974	0·40
Office of Health Economics. The National Health Service reorganisation.	*O.H.E.*	1974	0·25
Stark, Murray D. Blueprint for health. *ISBN 0 04 616012 4.*	*Allen & Unwin*	1973	4·50
National Health Reorganisation: England. Cmnd. 5055. *ISBN 0 10 150550 7.*	*HMSO*	1972	0·68
National Health Service Reorganisation in Wales. Cmnd. 5057. *ISBN 0 10 150570 1.*	*HMSO*	1972	0·26½
Reorganisation of the Scottish Health Services. Cmnd. 4739. *ISBN 0 10 147340 0.*	*HMSO*	1971	0·12½
Management Arrangements for the Reorganised National Health Service. *ISBN 0 11 320485 X.*	*HMSO*	1972	0·75
Better Services for the Mentally Handicapped. Cmnd. 4683. *ISBN 0 10 146830 X.*	*HMSO*	1971	0·45
National Health Service Facilities for Private Patients. Fourth report from the Expenditure Committee . . . Session 1970–71. HC 172. *ISBN 0 10 217272 2.*	*HMSO*	1972	3·95
Care of the Elderly in Britain. COI reference pamphlet. *ISBN 0 11 700670 X*	*HMSO*	1974	0·34
Rehabilitation and Care of Disabled People in Britain. Reference pamphlet. R4972/72.	*COI*	1972	0·74

Annual and Periodical Publications

Central Health Services Council.	*HMSO*
Department of Health and Social Security.	*HMSO*
On the State of Public Health.	*HMSO*
Health Education Council.	*The Council*
Health and Personal Social Services Statistics for England and Wales (with summary tables for Great Britain).	*HMSO*
Health of the School Child.	*HMSO*
Health Services in Scotland.	*HMSO*
Hospitals and Health Services Year Book.	*Institute of Health Service Administrators*
Medical Research Council.	*HMSO*
Nuffield Provincial Hospitals Trust: Problems and Progress in Medical Care.	*Oxford University Press*
Registrar General's Statistical Review of England and Wales.	*HMSO*
Scottish Health Statistics.	*HMSO*

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Prepared by the Central Office of Information

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